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This report contains selected papers presented by a group of consulting psychologists and state rehabilitation officials who attended a four-day institute at the University of Florida in 1968. The purpose of the Institute was to permit the two groups to explore the advantages of extending the range of psychological services to clients and personnel of the official agency. The report contains papers dealing with the problems, mutual interests and modes of interaction between psychologists and rehabilitation counselors. It is hoped that this report will help psychologists not already serving rehabilitation agencies to investigate the need for their skills. Counselors and agency personnel may benefit from a new look at the role of psychology as a necessary ingredient in the rehabilitation process. Some papers included in this report are: (1) "The Changing Role of Psychology in Rehabilitation," by E. J. Bourque, (2) "Identifying and Evaluating Behavior Disorders," by Hugh C. Davis, (3) "Meaningful Psychological Services," by John E. Mathard, and (4) Recommendations: Use of Psychologists in Vocational Rehabilitation. (Author/KJ)

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PSYCHOLOGICAL SERVICES
IN
VOCATIONAL REHABILITATION

CONFERENCE
PROCEEDINGS

SPONSORED BY

REHABILITATION COUNSELING DEPARTMENT, COLLEGE OF HEALTH
RELATED PROFESSIONS, J. HILLIS MILLER HEALTH
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AND

SOCIAL AND REHABILITATION SERVICES, DEPARTMENT
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PSYCHOLOGICAL SERVICES IN VOCATIONAL REHABILITATION

Conference
Proceedings

Sponsored by

Rehabilitation Counseling Department, College of Health
Related Professions, J. Hillis Miller Medical
Center, University of Florida, Gainesville

and

Social and Rehabilitation Services, Department
of Health, Education and Welfare
Region IV, Atlanta, Georgia

Editor

Ellsworth J. Bourque, Ed.D.

March 1968

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PREFACE

This report contains selected papers presented by a group of consulting psychologists and state rehabilitation officials who attended a four-day institute on the role of psychology held at the University of Florida during March 19-22, 1968.

Sponsored by the Rehabilitation Counseling Department, College of Health Related Professions, University of Florida and the Regional Office of the Social and Rehabilitation Service, Atlanta, Georgia, its purpose was to permit the two groups to explore the advantages of extending the range of psychological services to clients and personnel of the official agency.

The report contains several thoughtful and carefully prepared papers dealing with the problems, mutual interests and modes of interaction between psychologists on the one hand and rehabilitation counselors on the other. In view of the apparent need for improving and expanding services to the disabled, the advantages of providing timely and appropriate services on behavioral issues were apparent to the conferrees..

The ideas and opinions contained in these papers should encourage psychologists not already serving rehabilitation agencies to investigate the need for their skills. Counselors and agency personnel may benefit from a new look at the role of psychology as a necessary ingredient in the rehabilitation process.

Ellsworth J. Bourque, Ed.D.

INTRODUCTORY COMMENTS

Darrel, J. Mase, Ph.D., Dean, College of Health Related
Professions, University of Florida

I think this meeting, which brings together psychologists and rehabilitation administrators, is long overdue. It strikes me as most important that S. R. S., which has for many years dealt with psychology in rehabilitation, should now decide to learn just what psychology and psychologists really are. There is a real good chance that those who attend this meeting will come out with guidelines that will set a pattern for the rest of the country.

We are happy that the College of Health Related Professions at the University of Florida has been able to make a contribution to bringing the profession of psychology and vocational rehabilitation into a closer working relationship. The time is ripe for some clear and purposeful thinking and mutual planning for the work ahead.

THE CHANGING ROLE OF PSYCHOLOGY IN REHABILITATION

Until quite recently, when new federal legislation broadened the scope of vocational rehabilitation services to include those handicapped by behavioral or social handicaps, the interaction between members of the psychology profession and rehabilitation workers has been spotty -- certainly much less in quality and quantity than the nature and severity of behavioral aspects of disability warrant. Studies of the frequency of psychological consultation in counselor case loads reveal that, by and large, it is the usual practice to request psychological services only when mental or emotional pathology constitutes the medical problem. While it is often the case that psychologists are not available, it is also evident that where they are available, there is a reluctance to include them in day-to-day rehabilitation activities.

Some ideas as to why rehabilitation and psychology have not developed close affiliations arise when one examines questions such as:

1. It is possible that rehabilitation counselors and psychologists do not work within conceptual areas which overlap? Do counselors deal with adjustment, while psychologists conceive of problems within a mental health or psychopathological frame.
2. Do counselors, because of the emphasis on psychological principles in their training, feel little need for additional data about the dynamics of behavior?
3. Does the limited, consultation role of the psychologist result in meaningful data translated into practical guides for counseling activities?
4. Do counselors seek services from appropriately trained psychologists or do they tend to assume that any psychologist can provide a complete array of services?
5. Are psychologists really interested in providing services to official rehabilitation agencies? Are fee schedules, kinds of services and ways of interacting with clients and personnel unattractive to psychologists?

Some of the following papers deal with these difficult questions, probably for the first time. The reader will, it is hoped, detect ways for bringing the two helping institutions closer together for the benefit of the disabled client.

Institute Topics

Dr. William M. Usdane, Director, Research and Demonstration Division, Social and Rehabilitation Service, H.E.W., Washington, as conference keynoter, describes, in his paper, an array of opportunities for psychologists to become involved in the newer dimensions of vocational rehabilitation, i.e., poverty programs, education and training those with behavioral disabilities, research, program development and evaluation. He leaves little doubt that those who develop guidelines at the Washington level fully appreciate the contributions psychologists can make to the field of rehabilitation.

The paper presented by Mr. Mario Barillas, rehabilitation administrator from the state of Iowa, speaks from three views: a) his perception of the role of the psychologist as a psychologist himself; b) the administrator's view of his state's use of psychologists and c) research results from an empirical study he has conducted on the variety of ways psychological services are integrated in agency operations in the various states of the country. The reader will find Mr. Barillas' comments to be hard-nosed and practical, dealing as it does with the issues of fee schedules, the competencies of psychologists and the effects they have on interdisciplinary conflict.

Dr. Hugh Davis, clinical psychologist and Associate Professor at the College of Health Related Professions, University of Florida surveys, in his paper, some basic theoretical concepts which he has found useful in understanding behavioral disorder. Embedded in actual case material, his conceptualizations ring true, for they have evolved out of his clinical involvement with patients in a medical setting.

Psychologists will note in the remarks of Dr. Cecil Harbin, Georgia's Rehabilitation Psychology Consultant, clues as to the usefulness of some specific tests. Addressing himself to the issue of competency, Dr. Harbin points to the pitfalls of hiring the wrong kind of psychologist to serve rehabilitation agency needs. The panel structure his state has developed is worthy of close examination.

Representing Florida's Division of Vocational Rehabilitation, Mr. David Schriemer presents a description of how his state is interpreting the newly legislated provisions of the Vocational Rehabilitation Act. Those from other states will be interested in his description of organizational structures and emphasis on close interaction with the profession of psychology.

Many psychologists have raised the question as to which kind of psychologist is appropriately trained to serve rehabilitation agencies and their clients. Long a student of counseling roles and functions, Dr. John Muthard, Chairman of the Rehabilitation Research Institute at the University of Florida, speaks out against inappropriate emphasis on psychopathology in evaluation as seen in the work of many clinical psychologists. The proper emphasis, declares Dr. Muthard, is one which describes the more healthy and positive aspects of personality. One can sense in his comments the conviction that counseling psychologists have been more on target in rehabilitation than others in the field.

The conference plan could not have selected a more appropriate person to deal with the psychological aspects of blindness than Mary Bauman. Extremely knowledgeable, she addresses herself to the role of empathy in psychological practice with those who are blind. As a leading educational psychologist and researcher, she challenges psychologists to personal involvement and commitment to her chosen field.

Much of the time of the conferrees was spent in small groups discussions. No effort was made to capture the lively conversations which took place. That they were fruitful is evidenced by the fact that most of the groups, selected on state residence, either reinforced their interest in a more formal relationship with the state psychological associations, or actually instructed those state administrators present to communicate with them in the near future.

The list of recommendations submitted by each state group reflect variability in attitudes toward psychology as well as a diversity of linking procedures.

Ellsworth J. Bourque, Ed.D.

NEW OPPORTUNITIES FOR PSYCHOLOGICAL SERVICES IN REHABILITATION

William H. Usdane, Ph.D. Director, Research and
Demonstration Division, S.R.S., H.E.W.

The hope is that psychologists will see the new opportunities for service that are presenting themselves and will keep one eye on their scientific heritage and the other eye on society's needs. If out of a budget of $24,750,000.00, which is going to be in just one of the several pockets that I am now in charge of, we are committed to engage in at least 4.5 millions worth of research and demonstration projects, either basic or applied, that have to do with the socially and culturally deprived, you can understand that there couldn't have been a more opportune time for this group to get together. We do need psychological services to help us over and beyond merely bringing jobs to people; merely finding the evaluation process in a more innovative approach. We do need psychological services, primarily for communities to understand how to work together and how to avoid a second Kerner Report.

Those of you who may have had the opportunity to read the recently published Kerner Report will find that an exceedingly great amount of money was poured into ghetto areas, high risk areas and riot areas, but the returns were minimal. The percentages of those who were helped, as revealed by a cost analysis of the amounts of money that were poured in by a variety of government agencies were almost negatively correlated with the results. Now something is wrong. Old patterns have to be thrown out or at least modified, and I think that there are some new roles and new innovations that we have to observe. First of all, I want to point out that our emphasis on new roles and new opportunities for psychological services is concerned as much with basic research as it is with applied. We are particularly interested in projects and in programs involving psychologists that would give us new hypotheses to test in applied situations.

NEED FOR A BASIC THEORY

We are now at a point where we must find out what underlying theory we are really attempting to base our applied research upon. This is the struggle we have been engaged in during the past twelve years. Perhaps the newest opportunity would be for us to develop types of theories which might best be applied to the socially and culturally deprived. Let me give you an example of that. The Bureau of the Budget came to us, very recently, gathered together severa of the psychologists in the new Social and Rehabilitation Service and said, "The Social and Rehabilitation Service was founded on the fact that the rehabilitation way, the individualized approach to problems is the most successful with the disabled. Will you ever work with the socially and culturally deprived, now that you have inherited the social welfare empire--the social and welfare problems, the unmarried mothers, the fugitive father, child day care centers? Where among your state programs can you show us that you actually worked with the socially and culturally deprived?" We all looked at each other. Do the state programs actually deal with the disability group called the socially and culturally deprived? Well, no. State mandates don't allow that. "What about your projects?" Well in the low cost housing areas we've got four of those, eight of another kind. The demonstration projects did work with the socially and culturally deprived, but in order to make sure that the state vocational rehabilitation agency was aboard, it turned out that many of the socially and culturally deprived have disabilities. I don't know of anybody who can't be thrown into a behaviorally disordered category, gardentype or otherwise. But the problem was that once you see the individuals enter the state program under the categories other than socially and culturally deprived, there is no way to sort out the fact that state vocational rehabilitation agencies have been working with the problems of social and cultural deprivation. After they quickly got through with prosthesis and orthosis and medical assistance and psychological testing, when the nitty-gritty came down to it, the counseling process was involved. What did you deal with? Social and cultural deprivation! Now how do we go over our records, Mr. Deputy Commissioner, and show the Bureau of the Budget that for these many years we could rename our 175 almost 200 thousand rehabilitants as actually being socially and culturally deprived? As Miss Switzer said, "You go down to Gainesville and throw that question at the state agency people and the psychologists and you tell them that we need three projects overnight that will indicate how to sort this out."

SERVICES FOR THE WELFARE CLIENT

I don't know how we do this retrospectively. There's really only one state that actually had a program since 1955 in dealing with the public assistance, non-disabled client--the state of Washington, as you know. We phoned several states and tried to find out. If you went over your R 300's could you pluck out the fact that these people were really socially and culturally deprived and that secondary characteristics were necessary in order that they could be slotted into your state vocational rehabilitation programs. Could you? I don't know, but I can tell you that if a project of that kind comes in and crosses anybody's desk, you would have to be ready to start it overnight. Don't indicate your willingness to do it--you'll have it.

A UNIVERSITY MODEL

If you begin to talk about new opportunities for psychological services, you will find that we have some patterns, and these patterns are clearly represented perhaps by programs on this campus. I think one of the finest examples of what I would call the triple threat of psychological services and the relationships with state agencies, would be first of all Bruce Thomason's program in which he works very closely with the state, it's true that he is training rehabilitation counselors (vocational psychologists) counseling psychologists or something else -- underline one, we won't go into that battle again -- but at least it has a psychological base. The second forward thrust which is very ascertainable here is the Rehabilitation Research Institute, which is a regional one, and which is tied in very carefully with the regional approach. Dr. Muthard's program has the combination of the Regional blessing, the university halo and applied research. You also have here Mr. Mills' two representatives, two psychologists at a meeting which clearly indicate the closely tied university state program, and they are all assembled under Allied Health Services--a kind of configuration which is probably the forward thrust of today. Is it not the forward thrust of tomorrow? This is a configuration of professional areas and subprofessional areas and areas of assistance in manpower needs which provides us with across the board administrative cohesiveness in dealing with problems of a social and rehabilitation nature. It's a model, and it's a model that is not only out there for people to see but obviously is being copied around the country--which I think is very good.

SUCCESS OR FAILURE - WHY?

The Chicago conference of the American Psychological Association of 1966 talked about new role opportunities in the professional preparation of clinical psychologists. They called it a science-professional role, or science-profession model. This model was related to a prospectus for producing a corps of well trained, professional skillful, science valuing clinical psychologists whose responsiveness to social needs would rest on a careful systematic observation of meaningful and complicated problems. And we now ask for a kind of project that we are desperately in need of -- I've mentioned it before but I don't think I've mentioned it to this approach, as a new psychological opportunity--a new opportunity for psychological services. What is the process within the rehabilitation facility which spells success or nonsuccess for the rehabilitant? Now if we can cross professional griefs, if you wish to use sociological organizational theory, which they pride themselves on devising and developing, fine, but I am requesting that psychologists do the research, basing their research on that theory. What is the impact of the organization on the disabled individual who goes through the rehabilitation process within a rehabilitation facility? And I urge you to consider this as a new opportunity for psychological scientific observation. We are not suggesting participant observation in the sociological sense, we are suggesting the meaningful observation of complicated problems by the psychologist.

Tyler and Spiceman, mention in the October Issue of The American Psychologist that psychological services to the handicapped are of high order;provide an environment for observation far before the current social upheavals. One could agree with these two authors, who wrote up the Boston conference on community psychology--which is a second part of the role--which came up with the characterization of the definition of the psychologist's community role as participant conceptualizer. Tyler and Spiceman point out that community psychology is applying scientific method, rather than scientific findings of psychology to community problems.

I want to stop here for a moment with the hair-raising fact that on a weekly basis there is at least one meeting of the group of researchers now under Miss Switzer to concern themselves with the combatting of possible riots this summer. And Miss Switzer in her inimitable and forceful way has turned to the psychologists and said, "You boys have all the answers--it's about time you did something. Tell me what to do close of business today." Now she may be--you have to know her--have to be doubly tough, in order to make sure that she is doubly tough. The point is that she means business, now that she has inherited the welfare administration, and there is a need to do something about how to combat these problems. The suggestion was made--this was a third approach for psychological opportunities, and that is the appropriate utilization of the disabled as aides in dealing with the social and vocational problems of those within the ghetto or contained of inner city areas.

What about a new innovative approach for using the disabled, not exploiting them but appropriately evaluating them and training them, but having them do the counseling in store fronts in our summer programs, or bringing to the store fronts at 103rd and 3rd and Lexington in New York, or East St. Louis, or Buffalo or in Cleveland, all those horrible northern cities, that's where the problems are, frankly, and doing something, giving them some assistance through our approach of providing jobs, appropriately evaluated jobs for the visibly disabled.

H.E.W. is the area in which this job is going to fall. O.E.O., as you know is having its difficulties. H.U.D. is just coming into prominence. Department of Labor is tied inextricably with this in P.L. 90-248, which is the new public welfare law under the Social Security Amendments. Under Title 4, Section 3, Department of Labor and S.R.S. have to work closely together in what is called the WIN program. Now we desperately need psychologists to help us in the WIN program and I'll tell you how we're going to ask you to help in the development of the use of our rehabilitation techniques with unmarried mothers.

Now in one of our projects, someone said, "Well," These were part of my own welfare staff, they said, "Well, it's different when you are working with a rehabilitation client, you have something which obviously you can help overcome. They've got a disfunctioning arm, or you have to help them with a brace, or obviously they are blind or they are deaf, and you don't deal with the nitty-gritty problems that we deal with in welfare." Well is this true?

THE NEED FOR A NEW CONCEPT OF TESTING

Anastasia, as you know, who is one of our greatest developers of thought in testing notes the disassociation of psychological testing from the mainstream of contemporary psychology. Unfortunately, she points out, those psychologists specializing in psychometrics have been devoting more and more of their efforts to finding techniques of test construction, while losing sight of the behavior they set out to measure. She is concerned with too much emphasis on testing and too little on psychology. This was in an article she wrote recently in The American Psychologist

While she clearly outlines problems of validity, confidentiality, communication of test results, etc., she includes an aspect that always concerned psychologists who are in rehabilitation, and now psychologists working with the new group. To criticize tests. Well, every psychological test measures a sample of behavior and insofar as culture affects behavior, its influence will and should be reflected in the test. Moreover, if we were to rule out cultural differentials from a test, we actually would, of course lower its validity against the criterion we are trying to predict. In other words the same cultural differential that impaired an individual's test performance is likely to handicap him in his school work, job performance, or whatever subsequent achievement we are trying to predict. The psychologist in the field of rehabilitation soon learns to consider the interaction of the initial test score and the available differential treatments. For example, given a certain score obtained by a cerebral palsy individual, with a particular cultural background, the psychologist in rehabilitation will always be concerned in predicting his college achievement only following a specified remedial rehabilitation facility program.

Years ago when working in New York, I often wondered about their frustrations and later on, understood them -- and this was the frustration of the eastern European, or the middle-Europe transplant to New York City at the last turn of the century, whose sons and daughters brought their cerebral palsied adolescents to the rehabilitation facilities. These parents' goals included two drives, popularly termed -- eat and read. When they found their cerebral palsied son with both mastication and perceptual difficulties, undoubtedly in their desperation they started the United Cerebral Palsy. This was the very group who put high order on the academic achievement. Those coming up from the East Side, and again high priority on the very act of eating.

It was about 1943 that I remember an article coming out, and I think it was really in response to these parents' pleas who saw college goal as the only one. But there was the article written, "Should a CP Go To College?" Well, why college was ever considered was beyond any of us who were working in rehabilitation facilities with the cerebral palsied, unless it was appropriately designed from an evaluation standpoint. But in that culture, everyone went to college. There were no alternatives, and it was the same desperation with inadequate test results that forced the psychologist to turn to work samples as an adjunct, to psychological tests. Certainly those who throw out standardized psychological tests and just use work sample ought to have their heads examined by a psychologist.

So desentization, reciprocal inhibition, operant conditioning, all of these were really and are part, probably the hidden dimensions of testing and therapy.

Who is to stop, to ascribe his underlying theory while he as a psychologist has to give service, has to practice, as individuals tumble, one after the other into the rehabilitation facility. He doesn't have time to develop new theoretical concepts.

THE NEW JOB FOR H.E.W.

We've got to, I think, pull ourselves together in order to deal with the population--the universe that now confronts us. S.R.S. went from 400 individuals on its staff to 2000. Miss Switzer went from a budget of 348 million to 2.5 billion. My own reflection, I went from what I thought was a very tidy sum, and a tidy staff of 21 to now 38, and it's a division which suddenly has four branches! Suddenly you see so many million to so many billion, the quantification bothers me a bit, but here we are with four branches. What is there now?

Let me give you a configuration of these four branches that I have. It just used to be the Division of Research and Demonstration. The first branch is the Research Rehabilitation Branch, that's the old V.R.A. It's just as it was--we still have a mandate of, I recall, 83, 565, Section 481 etc. But if you should come in with a project concerning unmarried mothers, we can do it! Cause, Miss Switzer told us to. The goals of our second branch that's called, the Cooperative Research Branch (Section 11-10). That is Section 11-10 of the Social Security Act which deals with a variety of research programs, one of which is Section 11-10. Section 11-10 states that it will support research related to the prevention and reduction of economic dependency. If that isn't the rehabilitation research branch, I don't know what is! It has a budget coming up of 5 million as against the other coming up with a new budget, of 24,750,000. Now here's the difference between Dr. Garrett and whoever else used to mastermind the welfare administration,--22 million. They used to go up on the hill for the past seven years for more money, and they went from 200 thousand to 2 million, which they have this year. I never minimize the magnificent testimony of the old V.R.A. on the hill, with the help of the Darell Mases, who came running up to testify, thank goodness, for us. But the program of our rehabilitation research went from a quarter of a million to the 25 million, where the others just very slightly went up. They support research for the prevention and reduction of economic dependency, either contracts or grants. What's the relationships of the grants--their grants come in 95-5. We've just decided in our own field that we would never allow less than 10% from the grantee. When we look for the rules about that we can't find them. It's just that we figured that in applied research, if it's a demonstration, the community ought to be able to ante up a little more, unless it's the kind of research like a rehabilitation research institute. They have their own advisory panels and act as we do.

The third branch is called the Demonstration Projects Branch. These are all new opportunities for you to think about. This is Section 11-15 of the Social Security Act.

The fourth branch is the Research Utilization Branch. We are committed to getting our material out in every way shape and fashion. The Research Utilization Branch can entertain projects, it actually has no budget of its own, but it can entertain projects and if you have a project concerned with research utilization you would merely send it into either Branch No. 1 or Branch No. 2,--but not branch No. 3. I didn't tell you that Branch No. 3, grants, that is the Demonstration Projects Branch, can only be given to state welfare administrations. It's a four million dollar program. Very surprising, a State Director of Welfare can write in and state that he wants to do a demonstration and asks for a waiver of the state law so that he can do this thing without having to do it all over the state. Then he gets his grant, might be $50,000, $100,000 under 11-15. He can then use that money once it crosses tha state line and he has it, to match other federal grants. It's the only grant program in Washington in which money, after it crosses the state line, can match. This has already happened. The State Welfare Director in Pennsylvania has just gotten a grant--an 11-15 grant. He's interested in a grant from the Rehabilitation Research Branch, and I had to say, "Fine, send it in." So one division chief is matching his money with another division chief through the state.

We've always said that when money crosses the state line it is your state money, but not to be matched for other federal money. Obviously it's your money, no strings attached.

THE NEED IN CORRECTIONS

Well, the next real opportunity is in the correctional field. New opportunities for psychological services must strongly enter the correctional field. The development of job site evaluations with regular employers must be masterminded by the psychologist, the rehabilitation counselor and the social worker. We must have a kind of team who will help employers--overcome their fears that the ex-federal offender will be caught with his hand in the till. Now master mind me some projects please! We can give contracts directly to employers. We prefer to give them to universities, facilities, state agencies. We would prefer to give a matching grant, for example to a state agency who would then enter a third party contract with employers, and put in psychologists in business and industry. You have to have a built in psychologist to hold the hand of the employer, let's do it--it's the new pattern. If you have to have a rehabilitation counselor attached to that industrial firm, on loan from the state rehabilitation agency and supported by one of our grants, please let's do it. It's a new opportunity. This would just widen the horizon for jobs for rehabilitation counselors.

PREVENTATIVE REHABILITATION

Another role for us is coming aboard, particularly in the field of alcoholism, drug abuse and suicide. I want to point out, Saad Nagi's project at Ohio State where he is studying the history and nature of disability, the historic process, the disability process, and we hope that he will come up with some answers in terms of prevention. Here again to find that Mr. Nagi was the Chairman of the Advisory Panel last year of one of the new rehabilitation branches in this division. Mr. Nagi was also on one of our advisory panels in the old

V.R.A. rehabilitation research. But we are getting great marriages with the marriage of welfare and rehabilitation.

It's not hard to visualize going from Nagi's project to preventative measures that would entail new psychological services. Our studies of dependency coming out of our Rehabilitation Research Institute at Northeastern should also point up some implications for preventive rehabilitation. Hitherto we have not always used the term preventative. As you know it has squatters' rights in the Public Health Service, but that's last year! Preventative rehabilitation is for us, and if you ascribe the preventive approach to the field of rehabilitation, certain disability categories come up immediately. Blindness, deafness--we haven't just called it that.

We suggest the use of the Minnesota Test of Vocational Needs put out by some of our projects. Need satisfying qualities of jobs--job satisfaction. They have potential for new opportunities for psychological services.

TESTS FOR THE BLIND

We are holding a research utilization conference for psychologists in the use of all the new psychological hardware we've developed in tests for blindness. The idea came from Texas Tech. They developed a new test and had grave problems with validity. We thought, we would throw that open to a meeting of psychologists.

PREDICTING SUCCESS OR FAILURE

A closely related study would be multiple regression equations to predict rehabilitation success. Our Alabama project, RD 15-18 (Eber) came up with six socioecomomic factors. Five counselor work patterns and ten client performance factors, all of which contributed to such prediction. Correct use of such equations can powerfully aid the counselor in his work as well as the client he is trying to help. Here's a new opportunity for you, and I think it gives us a great assist.

We need a new thrust in suicide projects studying what we call partial suicide. Special counseling on psychiatric services. Special rehabilitation provisions for those who have been largely instrumental in bringing on their own impairments, so that by not returning to harmful behaviors they would defeat the best efforts of rehabilitation by becoming disabled again. Suicide is the tenth leading cause of death in our nation and in response to this problem there are already forty suicide prevention centers in the 17 states and the District of Columbia. Menninger has pointed up the incidence of partial suicide, which is a concept which should be of great interest to us in rehabilitation. It involves harmful behaviors, it induces impairments, the impact on the family is devastating. We've done nothing about this. With almost 2000 projects at least in our shop, none on suicide. There are so many things for us to do. There are just too few psychologists to go around.

Griffis, studying two hundred consecutive applicants for Social Security benefits concluded that 39% had, to a visible and substantial extent, contributed to their own impairment. Well if you begin to think in terms of the mentally involved, this is a revolving door approach. Of the 200 in the 39%, 26 had emphysema as a primary or secondary diagnosis and 21 of these 26 had smoked at least the equivalent of one pack of cigarettes a day for thirty years, that is, total cigarette consumption for each of the 21 ranged upward from this minimum. And of course similar startling figures can be found for cardiovascular cases.

Another project that might consist of new opportunities for OASDR clients was our OASDR project, #Rd1337; the project in Washington D.C. was what I would call perhaps confrontation counseling. Is it the William-Gliser technique? Basically the counselor confronted the client unswervingly with the counselor's conviction that the client could and should return to work. Constant pressure to produce attitudes favorable to work and to destroy the client's concept of unemployability was maintained. This pressure tried to gear him back to work by precluding all other solutions. The counselor neither accepted nor tolerated any refusal to return to work, did not hesitate to play God by degenerating unemployment, praising work values, assuring client of his all out support as long the client put forth effort in accord with those values. Cases were closed within less than six months. There were many contacts with the client both before and after placement and of the sample of the population 74% were successful. In all of our other OSDR Projects the percentage was about 25-30%. I don't know whether it works, maybe it's the personality, but I commend this project to you, at least for your review.

A THINK TANK FOR REHABILITATION

My other hope, and this is what I leave you with last in new psychological services is this: Stanford has it's "Think Tank"--a center for behavioral sciences. Why can't we produce somewhere a clinical tank where university professors, state rehabilitation administrators, regional deputy commissioners even central office staff bureaucrats could go. There would be a population of the disabled. The clinical team would be made up of these experts. Now instead of going off to center for a grant to study in the behavioral sciences or to write your book, some of you may want to go back into clinical service. We would have someplace, somewhere, a laboratory, client population in which all of us would get a retread. We would go back into harness. Now you and I know that staff turnover is so great in many of our rehabilitation facilities that you cannot tell me that the turnover every six months is not going to have an impact on the clients. So I bring you as the last suggestion for a new psychological service, a clinical laboratory in which two things would occur, the experts would get themselves in harness once more and they would also test out the significant findings of some of our research results. New psychological services could be tested out by experts.

EXEMPLARY MODELS OF PSYCHOLOGICAL SERVICES IN REHABILITATION

Mr. Mario Barillas
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From a number of sources we already have a good idea that there is no such thing as a national organization of vocational rehabilitation or at least what can be said is that almost all characteristics of the state programs are not normally distributed. As one study phrased it, it's no secret that there are many differences unique to each of the 90 agencies and that they could be described as 90 different programs. From another point of view reported in the February 1968 issue of the NRCA BULLETIN, which addressed itself to the issue of rehabilitation counselor's qualifications, salaries and benefits, the authors wrote in their concluding paragraph that rehabilitation counselors are very dissimilar in terms of salaries, educational and experience requirements, travel compensations etc. Therefore, it is difficult to speak of a national rehabilitation program when in fact we have operationally 90 programs.

Variability of Agency Characteristics

To further compound the problem, there are not only differences between states but variability within states is frequent. Where such a situation exists, it is meaningless to make general statements with regard to the professional role or status of the rehabilitation counselor in America. I can recall my own personal experiences, when a number of us were working on Caseload Management for IRS. Our committee very quickly, in trying to come to grips with this issue, noted the wide variation that exists across any dimension that you wanted to talk about in the rehabilitation program. Let me give you an example. The mean area served per counselor in square miles was found to be 2,000 with a standard deviation of about 1,900. And you know what kind of distribution that gives you! Another dimension -- the population served per counselor. The mean population was found to be 92,940 with a standard deviation of 33,000. This was taken from our publication, The Training Guide in Caseload Management, Proceedings of the Third Institute on Rehabilitation Services. If you'd like a copy of this I'm sure Dr. Muthard has a closet full of them. Dr. Muthard was the editor of that particular publication.

Well, those brief examples are just my way of illustrating that from a number of sources we have been told that there is a tremendous amount of variability amongst states and their practices and it is only reasonable that the same would hold true if we were to take a look at psychological services.

A Survey of Psychological Services

In order to test this major impression we used a relatively straightforward approach. We wrote a number of the state agencies asking their help in making us more informed about what's going on by way of psychological services. I asked them to send me copies of pertinent memoranda or manual sections or other documents that describe the extent of and procedures for providing psychological services within their respective agencies. I also wanted to know how psychologists fit into their organizational structure. Finally I asked them to give me their impressions of how satisfied they were with this aspect of their agency and any ideas they might have as to how psychological services might be strengthened.

I sent out 40 to 45 letters requesting this information. This was accomplished simply by going through the directory of general agencies and selecting from the state level individuals to whom I might address myself in an informal manner. I deliberately tried to keep the questionnaire at a level that would maximize their responding in an informal manner and thereby assuring myself of a response. I hoped they would not say, "Here is just another darn survey," and file it among many others that they had already received.

I would like to present the results in a non-statistical fashion and give you the highlights of a few of these responses. Then go on to see if there might be some general conclusions that we can reach on the basis of these impressions.

Results

My major hypothesis was very clearly substantiated. Namely, that there is a great deal of variation from state to state, across all dimensions. This ranges from those agencies that have no psychologists as such but obtain all psychological services from individuals outside of the agency at one end of the spectrum to those that have a full-time consultant. Among the more fascinating responses to this aspect of my letter was one state reporting, "no formal provision of psychological services for our clients. Required services are obtained from private sources and other agencies." However by way of clarification this individual did go on to point out that there were four MA level positions budgeted for, as well as one Ph.D. position, but all of these positions were as yet unfilled. He also mentioned that their staff was currently assessing the need for psychological assessment and had raised the question as to whether their need is greater for a psychometrist or for a clinical psychologist.

Another agency that used only outside assistance mentioned that all psychologist employed by them on a consultant basis had to be certified by their State Bureau of Licensing and Regulations. He went on to point out that many psychologists are offering professional services "outside of their regular employment obligations," This moonlighting practice seemed to satisfy the state agency because they felt this practice was "practical and economic to the agency since such individuals had no particular overhead or office expenses that would add to the costs of the assessment of individual clients."

At the other end of the spectrum were those agencies that did have full-time services of a psychologist at the state level. His major responsibilities included teaching to improve staff's ability to handle things psychologic. He also was the major negotiator in the establishment of fee schedules, and spent a great deal of his time in policing the activities of outside psychologists. He approved the applicants for panels of psychologists and periodically reviewed the work of these panel members.

Another state had the services of a very competent, well trained psychologist who also had responsibility for counselors in the district offices. By working through them, he hoped to free himself to do other kinds of consultation. In one state the psychological consultant had requested and received authorization for hiring consultants for each of their district offices. However he felt that he was handicapped in that they are restricted to a per diem fee which could not be exceeded and therefore he had great difficulty hiring. He hoped that his request for a substantial increase (almost 50%) would help him in this regard. He complained that he is only able to "put out fires" and he's so busy maintaining standards of fees and spot checking the work of the panel psychologists and those who apply for these panel psychologist positions, that his time is pretty well occupied.

So we have on the one hand a number of agencies that have no formal provision for the employment of psychologists on their own staff to those agencies that have a fairly well articulated program of psychological services.

Patterns of Services

Within those agencies that have well articulated programs of psychological services we also see quite a variation in patterns. In some states it is still the current practice for rehabilitation counselors to do the psychological testing. Outside psychologists are used as consultants only in those cases that are felt by the counselor to be beyond his level of competence. In at least one of these agencies, the state psychologist assumes responsibility for coordinating and correlating the work of these counselors. He is responsible for their kits of psychological tests and I assume orders the necessary amounts of testing supplies to keep all the counselors supplied. He is also responsible for the continuing staff development of these counselors to become more sophisticated in psychological assessment techniques.

Some Guidelines for Psychological Services

In trying to trace the beginnings of this movement, I found that at a Workshop in 1947 the Committee on Psychological Service of the G.T.P. had presented recommendations in four fields.

1. Standards for psychological evaluation of rehabilitation clients were recommended.

2. A minimum basic testing kit for each rehabilitation counselor (its adoption was recommended).

3. A plan for the instruction of counselors in the elements of selection, administering and interpreting psychological tests with special attention to those included in the counselors testing kit.

4. Suggestions in regard to the best method of instructing counselors in principles of good interviewing.

By 1949 just two years later, the committee reported that the Counselors Basic Testing kit had been well received. Seven states had adopted the kit and the recommended method for instructing counselors in its use. Six other states reported using the kit but not the recommended method for instructions. Still other states were using a comparable kit.

The committee turned to other areas -- let me just briefly, quote from their report because it states their position so well.

1. Selection of A Panel of Qualified Psychologists

> The state-federal program of civilian vocational rehabilitation has always subscribed to the principle that services of the highest quality should be provided to its clients. This principle is stated or implied in State and Federal regulations, in agency policies, in

> public and scientific releases, and is implemented in case work manuals and every day practice. Moreover, experience has proved that quality services are the most economical. Money spent on services of doubtful quality is being 'penny-wise and pound foolish'
>
> In providing psychological testing for rehabilitation clients, the state agencies must be assured that the evaluations are competent, accurate and thorough. The effectiveness of counseling and the clients successful adjustment depend upon the result of psychological evaluation. Since the welfare of the client is so much at stake, every reasonable effort should be made to furnish psychological tests and evaluations where quality is beyond question.
>
> The committee fully recognized that certain clients require psychological evaluation of a level of skill which goes beyond that which the counselor can furnish through use of his counseling testing kit. These cases demand the services of psychologists who are qualified and experienced as specialists in their field. It will be necessary, then, for the state agency to furnish to the counselors a list of psychologists whose competence and qualifications are approved.
>
> The committee also recognized that the panel of qualified psychologists should be based upon standards set up by the profession itself. Such standards today are available. Rehabilitation agencies should be sufficiently acquainted with them in order to identify qualified psychologists.

In another section of this report, a procedure is spelled out for the development of a program of psychological services and it goes on to say, "The supervisor of G.T.P. should be the key person in the development of the program described above. It will be necessary for him to follow the above suggestions and to guide the developments that take place. Special attention to the program will be necessary in the early stages."

The Counselor vis-a-vis the Psychologist

In other states, such as Iowa, counselors are prohibited from administering and scoring psychological tests. The administration feels that counselors have enough to do without trying to become experts in this area too. They feel that in the long run the client is more nearly assured of quality services if these are obtained through individuals who are psychologists by identification. Despite this constraint, the sequence of courses the counselors go through is almost identical with that of a M.A. level psychology program.

Another pattern emerges in those settings that have had extensive experience with an inter-disciplinary team approach to rehabilitation. This is particularly true of states that have had Evaluation Center experiences or agreements with other institutions. In these agencies we find psychologists operating as a team with theoretically equal responsibility and authority except that in most of these instances, because the counselor is given agency responsibility for "handling the case", the psychologist probably needs to accept at least nominal supervision and direction from the rehabilitation counselor. In other words it is the counselor who controls the client. He has access to technical information that can be provided to him by the psychologist but whether or not he elects to use and take advantage of these skills is left up to the judgment of the counselor. In several states, psychological services are being made available by hiring psychologists and putting them into district offices along with social workers and other specialists.

In all agencies that responded it was found that psychologists were used as specialists to assist in the establishment of eligibility. A number of the states quoted from their manuals the requirement for a psychological assessment to be part of the case file in all instances of mental retardation. They also pointed out the option of using psychological services and/or pyychiatric consultation in the establishment of a behavioral disorder as the major disabling condition. In fewer agencies are psychologists used for treatment services. Where they are used for treatment, it is interesting to note that language other than psychotherapy is used to identify the service. These states used such words as "personal adjustment treatment" or "personal adjustment counseling" and they pointed out that they have a great deal of autonomy in authorizing services on a needs basis, once the individual who is to provide it agrees to a number of requirements such as the recording of the actual amount of time for each session, the need for periodic formal reports to be submitted in writing as part of the permanent record. At least one state had what I thought was a significant dimension built into their program; that is the requirement that the psychologist who submits a report would make himself available to consult with the counselor about the case in question.

Fees

I don't think I can get away without at least a passing reference to fees, for they are a perfect example of the variation that exists in practice from state to state. For instance, in some states the fee schedule is established in cooperation with a committee representing the state psychological association. In others, the fee schedule is established primarily by the psychologists on the staff of the state agency with some limited and circumscribed involvement of a few interested psychologists. And in still other states the fee schedule seems to be developed by a member of the administrative staff of the state agency without any formal involvement of psychologists.

The amounts paid for testing and for what kind of testing also vary markedly from state to state. Some states have a very elaborately developed fee schedule with a dollar value placed on each test. These testing lists and the dollar amounts payable for each run to several pages in length. It is the counselor's responsibility to request each test of the examiner.

In other states the counselor's responsibility is to define the area of interest, such as intelligence, personality, interest or aptitudes and then within each of these areas the psychologist is free to choose from among a number of instruments those with which he is most comfortable and which in his judgement, seem to be the most appropriate to the case in point. Several states encourage the counselor to ask fairly specific questions of the psychologist. For example, "Can he make it as a barber? Should he go to college?" etc. Here the psychologist has even more flexibility and is encouraged to use whatever instruments he feels are related to answering the specific questions raised by the counselor.

One of the more interesting approaches to psychological testing was found in the state that had a fee schedule based on the number of hours spent in psychological consultation. This permitted the psychologist to charge not only for the pre-testing interview with the client and the actual time of test administration but it also permitted him to charge for the time to score and write the report and beyond this the most significant factor seemed to be that this permitted him some time to engage in a face-to-face consultation with the referring counselor. This option of consultation built into each request for technical information would seem to go a long way toward overcoming some of the major communication barriers that now exist between the two disciplines.

Psychological Treatment

The above relate primarily to diagnostic or evaluative services. If we were to turn to treatment of a psychological nature we would find again a great deal of variance in practice from one state to another. For example most states continue to consider psychotherapy as a medical service which "can be performed only by a psychiatrist working under his direction and according to his specific prescription for the individual case. Consequently we rarely if ever purchase psychotherapy from a psychologist." Other states have a more flexible system of authorizing psychotherapy directly to a qualified psychologist whether or not the psychologist is affiliated with a psychiatrist. In some of these states they get around the question of whether or not psychotherapy is a medical service by referring to what a psychologist does by way of treatment as personal adjustment counseling.

The Need for New Kinds of Consultative Services

It was interesting to me to note the very rapid drop-off of psychological involvement as you move from the direct services to clients to areas that might be considered supervisory administrative or policy making. And it is this issue to which I think we could all earnestly address ourselves for at least the remainder of this morning.

It seems to me that psychologists have very clearly demonstrated their ability to provide direct services to disabled people. In this regard there is no question but that a number of individual states were brought to this point by the language of the amendments to the rehabilitation act. In fact several of the state agencies pointed this out that this was a legal requirement and in order to meet this requirement they had developed such procedures. I'm talking now primarily of the need for psychological assessment in the areas of confirming the existence of mental retardation and now with the increased emphasis being placed on the accurate identification of individuals with behavioral disorders. However a much, much, much smaller percent of all psychologists in rehabilitation are being used in supervisory capacities in situations where they would have line responsibility for the work behavior and performance of other people on the rehabilitation staff. The exceptions to this seemed to be in those large agencies where it was just a question of pyramiding, because of the size of the agency, and in those agencies that had their own centers or facilities where the departmental status of psychology had been included in the operational framework of the facility. But with these two exceptions there was relatively little indication that the psychologist was seen as a potentially valuable, contributing member of the state agencies organization structure, particularly in areas that we had come to regard as being well within the purview of skills that we had to offer. Permit me to mention at least three of these:

1. I came from the school of psychology that said that regardless of the type of situation in which you find yourself the psychological training that you have received should uniquely equip you to be analytic in your approach, objective in your assessment and constructive in the approaches that you take to problem solving. It has been my experience that these skills are very much in demand.

Indeed all administrators that I'm familiar with cry for this kind of help. Yet as a national movement there has been relatively little done to call on psychologists as psychologists to man these critical areas within state agency operations.

2. Another area where I had been lead to believe that psychologists could make a major contribution is in the area of in-service training, and staff development. As experts in the field of learning, we know how to teach, to motivate, to instill fervor, to manipulate. We are sensitive to propaganda and it's positive use. We are aware of the impediments that keep people from learning. Yet I find, across the country, that relatively little use is made of Psychologists as psychologists in filling this very vital role in state rehabilitation agencies.

3. In not a single one of the twenty odd responses that I received did I find any specific reference to the potential utilisation of psychologists in the area of research. If there is one direction in which every one of our graduate schools and all our previous training has lead us to think is one ultimate and perhaps the only satisfactory approach to the solution of human problems, the scientific one, it is one area where we have not been called upon by the state agencies.

Satisfaction With Psychological Services

Most of the agencies that responded to this particular aspect of my probing led me to believe that they were very unhappy with the state of affairs. "Our state as elsewhere is experiencing a tremendous shortage of qualified psychologists. We feel that in too many cases psychological services are hard to come by and in many cases totally inadequate. Our long range plans will hopefully provide for additional full-time psychologists to be included on our staff. Until this service can be provided I doubt if we will ever be completely satisfied.

"Of course, we are not satisfied. We feel that there are many fields that require continuous concern. This is one of those fields. What we can do about it is another problem?"

"The fact that we have asked for psychologists as additions to our staff indicates that we are not completely satisfied with our present manner of obtaining psychological services."

"We are not satisfied with our program of psychological services. This can be attributed to the following factors:

1. Inadequacy of state office direction
2. Difficulty in recruiting qualified staff
3. Lack of adequate standards of service
4. Unavailability of psychologists from whom services can be purchased
5. Lack of programs for interns in psychology
6. Absence of licensing requirements for psychologists
7. Lack of qualified persons to serve as psychological consultants for most field offices.

8. Use of psychologists largely in vocational evaluation in contrast to individual or group counseling."

Only a few agencies reported some degree of satisfaction with their present situation.

"We feel that the services we are getting are adequate and serve our needs. Yet we remind the counselors that psychological services should not become a crutch."

"Generally this system of staff and contract psychologists serve our needs appropriately. In common with other agencies however we experience a shortage of qualified psychologists and greater number of these professionals would be desirable to expedite our client services."

And finally, one of the most delightful comments, "Haven't really given any thought to evaluating this material or making any new suggestions or recommendations."

Recommendations

It seems evident to me that much more attention needs to be given to the role of psychological services in state rehabilitation agencies. I think this conference is a very good beginning but only a beginning of the great amount of work that needs to be done if we are to come a little closer to what we all subscribe, namely, the provision of high quality services to those entrusted to our care.

As a further beginning, we might all take another look at the model that has been developed so laboriously over the years of medical services in vocational rehabilitation and adapt from our experiences with this older, more structured professional organization those techniques which have stood the tests of time. I have in mind such concepts as the use of a) professional advisory committees to the Director and his state level staff to b) assist in the formulation of policy, c) the establishment of an equitable fee schedule that is more realistic and in keeping with a variety of concerns, d) to handle issues of questionable professional practice, e) the establishment of face-to-face consultative services at the district office level which would assure the availability of knowledgeable individuals to the counselor to answer those technical questions that may have well been beyond the training he received while in school or that he can receive on the job.

It seems to me that the major responsibility for this leadership is at the federal level.

Within the agency administrative structure itself, it seems that we can move much further toward the establishment of psychological services as a valuable and contributing unit that would provide expert consultation to administrative and supervisory staff with sufficient status and pay to assure the availability of competent, dedicated individuals. That this division within the state agency have sufficient flexibility and professional freedom to develop programs within the broad framework of state agency policy and that this unit have access to sufficient financial and manpower resources to carry out it's part of the mission. The responsibilities for this unit might well include research at the operational, as well as the administrative levels, consultation services to the administrators and supervisors, teaching as well as other more direct service-related activities and responsibilities.

As one example of this is the situation whereby the state director is required to approve an application for an R & D grant. He might well use the services of a knowledgeable person in this area. Another area is that of a "change agent" who stands between the researchers and the user of research findings and who relates to both and is responsive to the needs of each.

IDENTIFYING AND EVALUATING BEHAVIOR DISORDERS

Hugh C. Davis, Jr., Ph.D.

I will begin my talk today by recounting what goes on in a brief span of clinical time for a clinical psychologist in the area of clinical cases. To begin with I will couch the case as a V.R. referral and note that the case begins with the referral, whether it is telephone, written, given in person by the referral source or with a confrontation of the patient himself. This referral sets off a series of questions and conjectures to identify cues from which to carry forward a clinical process the ultimate aim of which is to satisfy with the greatest efficiency and accuracy the problems being referred. The problems always involve the referral source, the patient, and his environment. (The environment may always be classified as interpersonal-social and non-interpersonal.)

The Clinical Problem

To return to my example though, a V.R. referral has requested examination of a 22 year old white single male and has cued the search by asking questions regarding intelligence, emotional adjustment and job training potential. Such questions specific to a degree as they are, prompt questions by the clinician as: What does he really want to know vs. that which he is asking us. This leads to questions of 1) What problem is the referral source having with this patient, 2) How long has the source been having this problem, 3) What difficulty is the patient having with the referral source by virtue of being in contact with him (it), 4) How did this contact develop, 5) And most importantly, what difficulties is the patient having that are independent and not a result of the referral source?

Behind the questions I have just phrased is the fact that a decision process is ongoing which will affect in one way or another the actions of the source, the patient, and his environment, and I might add the referral environment as well. This decision process is as easily labeled as information gathering to facilitate differential behavior on the parts of each toward the other.

The Referral Source

Experience with the referral source and its typical referral questions are frequently translatable into very precise questions of: "I've been attempting to terminate treatment with this patient who was doing fine, but now has noted having some suicidal thoughts: Is there much of a risk? Should I stop pushing him? How attached is the patient to his mother and vice versa? How do you think leaving home for a different environment for training would affect the person, or is treatment necessary to accompany training or should it precede it?"

It is these everyday questions between clinical psychologists, referral sources and patients that contain elements of both clinical and scientific concern; and it is some of the interrelationships about which I want to speak today.

In order to do this I will describe a composite case referral, some of the actions implied and note the cues in the situation which are translatable into some scientific problems and concerns.

A Sample Case

I earlier noted the V.R. referral of a 22 year old white single male requesting information on intelligence, emotionality and job training potential. Let me describe some of the actions.

The referral was by mail and telephone to our secretary. At the appointed time the patient appears alone for his appointment at our center. In the interim between referral and appointment time a tentative strategy of assessment has been devised. The patient is sitting waiting in the patient waiting area and haltingly rises as the psychologist indicated with assurance that he, the patient, does indeed have an appointment with the psychologist on this day and time. The patient walks slightly behind the psychologist to the examining room and selects, after a pause, a chair matching in comfort another chair at a table but less comfortable appearing than a third chair.

It was confirmed he had talked with a counselor about job training and that he currently was working for the state in the park service. It was determined he had completed 9 grades of education but did not return for the 10th.

He tends to be slightly built, with sandy reddish hair, asks few questions, smiles appropriately, answers easy questions briefly and tends to become inhibited and has difficulty in answering more complicated questions about feelings, likes and dislikes, and about friends, family and interests. These latter he seems to take for granted. He indicates some disappointment in a few words over having dropped out of school and without saying, indicated a lack of interest. He didn't fail any grades. He has worked mostly at pick-up jobs requiring relatively low skill manual and/or service activities. He likes his present work within the park service which is essentially labor involving clearing, policing and constructional type activities. He wants to improve upon his work skills but is non-specific as to what or how.

He has a girl friend but indicates some social embarrassment in talking about their relationship which was prompted by impersonal questions. He considers himself physically healthy. His open neck sports shirt and trousers are clean and pressed, though his personal care as regards hair, nails and cleanliness suggest some inattention to details.

Without saying so, he gives the impression of not really being sure why he's talking with the psychologist about himself or for that matter even why he is here. He appears willing to cooperate with whatever comes his way in this situation though it is doubtless novel and complex and uncomfortable for him.

It was further determined that he lived at home with his father, mother, three younger siblings all in school and an older sister was married living away. His father, a moderately skilled garage mechanic has worked irregularly for the past several years as a result of an ulcer and a job related back injury. The patient contributes money weekly to the family income.

Further questions elucidated that when twenty he had been held overnight and released by police for having slugged and hurt a friend of a friend who had made insulting remarks about his girl friend. He freely admitted he used to have a temper around pubertal age which resulted in angry outbursts with some fights. Lastly, he noted having been a bed-wetter until around 13 years. An abbreviated

W.A.I.S. Scale was given from which were derived F.S.I.Q. 90, V.I.Q. 89, P.I.Q. 93. He completed an M.M.P.I. and a Sentence Completion Test. The M.M.P.I. Scales 4 and 3 were slightly elevated with no other scales over T score 70.

He is scheduled for interest and aptitude testing by a rehabilitation counselor. The session was terminated after patient time investment of three hours. Over the period of a month several young males were seen who presented quite different specifics but in their more general characteristics are similar.

As a psychologist I am somewhat surprised and quizzical about the number of such referrals from rehabilitation.

I return now and ask: "Who is this young man? What does he want? Does he need help? With what? Who and what can help if he needs it? Do you recognize him?" My additional questions are does he and the clinical episode present problems of concern to the science of psychology as well as the profession, what are the questions, and are there any answers?

Scientific Issues and Clinical Observation

Psychological science is classically concerned with questions of reliability and validity. Peter Nathan[1] in a recent book concludes with: "Even at this point in the development of procedures for utilizing E.D.P. equipment in diagnostic research most of the problems attendant on programming the equipment for large scale correlational studies have been solved. What remains as the major stumbling block to an effort such as we anticipate is the omnipresent problems of reliability: How does one go about defining and then gathering reliable data on the psychopathological behavior of patients for computer input?" With our patient in question, we have identified through interview certain developmental difficulties as prolonged bed-wetting, angry outbursts, school dropout, and attack behavior (defensive) with anger. We have currently observed a generalized tendency to social dependence, low assertiveness, a tendency to social embarrassment about personal heterosexual matters elicited by impersonal questions, and some inattentiveness to physical care. We have further utilized instruments of researched reliabilities and validities regarding questions of intelligence and behavior dispositions elicited from one response modality, i.e. verbal yes and no questions.

Have we reliably observed the patient? I think yes, as far as it goes. Many additional observational settings could be structured and these could involve reports from a variety of sources, professional and laymen. Zubin[2] I think notes accurately regarding psychopathological behavior: "Until other indices are available, we depend on behavior deviation from socio-cultural norms for diagnosis." He adds in support of this point, that detection, rather than diagnosis, is made largely by laymen, that is, the patient himself, his family, friends, neighbors, community and public officials. There is evidence by Katz[3] among others, that families can report with high reliability on degree and frequency of difficulties returned hospital patients are experiencing. Such resources could be and are used as observational sources.

Issues of Validity

Assuming reliability we will yet want to know about validity. In our patient case we are concerned lest the salient cues we have regarding aspects of his behavior dispositions and intellignece have generality and are true about him in the sense of determining action. Put another way lets ask the question: "Now that we have described his behavior have we explained it?"

Staats and Staats[4] write that the mere systematic recording and classification of observation is an improvement on non-scientific interest, since it enables us to notice relationships that would never be apparent on the basis of casual observation. They further note that the stuff out of which the lawful relationships are found are the observations of the events in which one is interested and the independent observations of the conditions that determine these events. In order to explain an event, something more than observing and describing similar events must be done. The antecedent conditions under which the event will occur must be known as well as the conditions under which it will not occur.

In the case of our patient we will want to know the conditions under which he does not exhibit social dependence, heterosexual embarrassment, and inattention to personal care, as well as the conditions under which he will exhibit attack with anger and angry outbursts.

For example, he reports work and family responsibility and currently appropriate behaviors toward supervision and with peers, without the implication of social dependence, anger, etc. It may be that his problem behaviors occur under conditions in which cooperation requirements, novelty and complexity are high, which frequently is described as an unstructured environment. Could this be shown then we are closer to an explanation of his behavior. Our tests and other data make a claim about inner states, in summary form we are calling dependency-conflict and low normal intelligence, and about which I have indicated relate to the scientific concern with validity and to explanation. Skinner[5] has commented as follows on explanation vs. description which has relevance to our case: "Trait-names usually begin as adjectives-- intelligent, aggressive, disorganized, introverted, dependent, etc. -- but the almost inevitable linguistic result is that adjectives give birth to nouns. The things to which these nouns refer are taken to be the active courses of aspects. We begin with intelligent behavior, pass first to behavior which shows intelligence, and then to behavior which is the effect of intelligence." One may continue using this logic to explain narcissism and paranoia.

Is a Transactional Model Needed?

The behavior cues in our case raise scientific problems of reliability and validity and of description and explanation. In further exploration of our patient and the conditions under which his behavior indicates difficulties we are dealing with the problem of environmental classification, as well as individual differences and modes of behavior of the patient. Our most general problem becomes that of accounting for sources of variation of the behaviors in question. Endler and Hunt[6] report in their studies and analysis of anxious behaviors that main effects of individual differences, of situations and of modes of response account for 1/3 of behavior variation, that the simple interactions among these account for 1/3 and that as yet an unanalyzable triple interaction account for the remaining third. The implications of this is to highlight the importance that the individual is not a closed system of behavior or completely inner determined and further that situations have "pulls" on general types of behavior, but not exclusive pulls. For example, some situations induce fairly high conformity responses, or pull for particular manifestations of autonomic responding. It is the property of the response to the pulls by which we judge appropriateness of behavior. A loss of a valued object tends to pull depression. Separation tends to pull dependency reactions. Hunt[6] concludes ". . . that the fact that interactions constitute approximately 1/3 of the variance implies that personality description can be improved by describing people in terms of the kinds of response they manifest in various situations.

Bellows[7] has called for a taxonomy of social situations and has empirically described them on a cooperation-authoritarian dimension. Authority he defined as constraint, "...the condition that guides and influences the behavior of a person or group in which they do not participate, indeed have no opportunity to do so, in deciding about the behavior." He has shown that conventional descriptions of places and activities are correlated with the authority-cooperation dimension. For example: situations and corresponding activities which have descending degrees of cooperation requirements and increasing amounts of constraint are: 1) graduate school, learning and research, 2) college instruction, 3) office work secretarial, and on to, 4) roadway construction, 5) routine military and 6) serving prison time.

An important hypothesis for our case might be that situations having high cooperation requirements are conditions for temper outbursts and social dependence; and that situations with more structure or constraint, as his current job, "pull" more adjustive performance and satisfaction. A further implication bearing on additional training would increase cooperation requirements over that of his current work situation and by implication increase the probability of social dependence and temper outbursts.

Our patient's problem with social embarrassment (a mode of anxiousness), along with his earlier anger outbursts and his attack behavior find additional meaning I think as we consider the social situation context of this behavior, and the degree of constraint in the situation. The scientific concern is that of taxonomy and of dimensionalizing environmental settings.

Is There A Base Line of Adjustment?

The second set of cues in our case as experienced by the clinician which present a scientific problem are those indicated by the registration of surprise and quizzicalness at this case and the several similar cases over a relatively brief interval. This is the problem of efficiency and accuracy of prediction as related to base-rate probabilities. I add at this point the surprise and quizzicality arose due to the fact this patient and the similar others represented a different referral population with most probably different base-rates of emotional disturbance, intellectual efficiency and job skills. This group were N.Y.C. individuals to whom V.R. has a screening and service assistance relationship. The effect of this "new" population would bring about adjustive alterations in the diagnostic prediction situation. This point may be viewed more clearly in a report by Paul Satz[8] on the efficiency of an instrument in detecting brain damage: "the results of this analysis indicate that under conditions of extreme base-rate asymmetry in which the incidence of brain damage is low (P=.10 IQ=.90), the diagnostician would be correct only 44 times in 100 when he predicted a brain lesion on the basis of a positive test sign with this instrument. This finding limits the usefulness of the instrument, with respect to this decision, for settings in which the incidence of brain injury is extremely low, (for example in Mental Hygiene Clinics). In all other populations, however, the efficiency of this test would be high. In fact, its greatest usefulness would be in an inpatient medical setting (P=.91) in which the incidence of brain disease is high (P=.60). Our clinical case represents a shift to a new population in which we might assume the base-rate is much more asymmetrical as regards emotional disturbance and job training potential, than in the more typical V.R. referrals. About asymmetry in base-rates Paul Meehl[9] states that: "In some circumstance, notably when the base-rates of the criterion classification deviate from a 50% split, use of a test sign having slight or moderate validity will result in an increase of erroneous clinical decisions." I would guess as regards emotional disturbance that the usual V.R. referrals had a base-rate nearer a 50-50 split. That is, nearer half of the referrals were in the "state of nature" behaviorably disturbed. For the new population a 10-90 split is probably more likely. Hence, the problem was one encountered quite frequently in the clinical situation, which is that of adjusting our signs and indicators of emotional disturbance to allow for base-rate effects. How we do this is to obtain additional information which alters the weight we give to particular cues. In our case I should weigh somewhat differently the patients easy reporting of defensive attack with anger than that of another patient with a different referral source and base-rate problem, a prison inmate for example. Meehl notes the chief reason for our ignorance of base-rates is simply that we do not record them. The area of scientific concern in this instance are conditions affecting predictive accuracy.

The Need for New Nosological Dimensions Based on Transaction

A third and last clinical experience and scientific problem is that of nosology. Our problem is to label or not label in a diagnostic sense. A best summary I could determine is given in a statement by Stengel[10] in which he states: ". . . that despite the limitations of the Kraepelinian system, it has continued to be the basis for classification of mental disorders in some form or other all over the world." The question faced by both the clinician and scientist is the amount of significant diagnostic information contained within a label of passive-aggressive personality, or emotionally unstable personality or even of mental retardation. When we test our nosological schema against its ability to sharpen in a believable way our knowledge of etiology, symptoms, behavior dynamics, treatment and intervention techniques, or prognosis, including spontaneous recovery, treatment participation, or recividism, we find our categories wanting. While a number of detailed classification schema exist they suffer along side the inherent limitations of the Kraepelinian Psychiatric Nosology. The Northeastern University studies[11] in definition of dependency in rehabilitation represents an improvement in one area of dysfunction and I cite their definitions:

1. Normative dependency including those clients accepting the goal of independent functioning and who see participation in societal structures as a means of achieving the goal.
2. Calculative dependency including clients who value independent functioning but reject the value of participation in normative systems of society. They would see themselves "earning a living" in part through participation in a rehabilitation program.
3. Ritual dependency includes clients who have lost sight of independent functioning but hold on to the value of honest participation in normative structures.
4. Anomic dependency includes clients who reject both goals and means of independent functioning.
5. Alienative dependency includes those clients who reject institutional goals and/or means and who attempt to replace or alter them. These would be our alienated and rebellious persons (e.g. Black Muslims).

The analysis and defining characteristics of dependency I submit is an improvement over our present diagnostic labeling categories in one area of dysfunctioning which is demonstrated by its conceptual utility.

In concluding, I would note that the Northeastern studies on dependency reduction in low income housing projects represent a better example of research demonstration which relates person-environment characteristics.

A history of science shows us, I think, that our views of ourselves and our environment proceeds from first viewing an object as possessing self-action, that is, the basis for the behavior is contained within the organism or object. This view proceeds to action which is an outcome of interacting forces. We now conceptualize action as an outcome of a transactional system, The transactional system is one in which a reciprocity is continuously occurring among the interacting objects, with mutual effects. Such a system would imply that a hurt to one is disturbed throughout the system, that a disturbed child may well be a disturbed family, that a hurt to one family member is a hurt to the family, that garbage piling up in the streets has presidential implications, or riots in the ghetto possibly parallels psychotherapy in suburbia.

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THE IMPORTANCE OF INTELLECTUAL ASSESSMENT AND PERSONALITY EVALUATION IN REHABILITATION PLANNING

Dr. Cecil Harbin

The most common type of service provided by psychologists to the Division of Vocational Rehabilitation is the psychological evaluation. Referrals from the general counselors are made primarily for two reasons:

1. To obtain information to be used in the determination of eligibility for vocational rehabilitation services and,

2. To obtain an assessment of intellectual and personality factors to be used as an aid in developing a vocational rehabilitation plan.

Valid But Not Useful

Obviously, the determination of eligibility and the development of a vocational rehabilitation plan are important aspects of the vocational rehabilitation program; consequently, it is essential that the psychologists provide services of high quality in these two areas. However, it is not sufficient for the psychological report to be just of high quality. The information may be perfectly valid and still not relevant and helpful. For the most part, clinical psychologists have worked with the emotionally disturbed and have been primarily concerned with treatment goals. As a result, it is not surprising that they have not always been aware of the types of problems for which the rehabilitation counselors are seeking solutions. I believe that we can be more effective in working with each other if we can learn to communicate better so that the psychologists know the needs of the rehabilitation counselors and the counselors know what services the psychologists can reasonably be expected to provide.

Selecting the Right Psychologist

As the State Psychological Consultant in Georgia and as a member of the DVR Psychological Advisory Committee, I have been involved in an effort aimed at improving quality and standards of psychological services. How does one go about improving services? My answer to that is that you establish clearly in your own mind what needs to be done and then you carefully select the right psychologist to do the job. And that's where the difficult problem really begins.

For many months now the DVR Psychological Advisory Committee has been working on this problem. Our aim has been to identify competent psychologists who could be depended upon to meet the needs for psychological services of all types. It is an understatement when I say that this has not been an easy task. We have not been satisfied with the way the present panel of psychologists is set up since it fails to designate special interests and special areas of competence. With this general type of panel, the assumption would seem to be that all psychologists are equally competent to perform all types of psychological services. Obviously, this is not true. A particular psychologist may be an excellent psychodiagnostician and have limited skills in psychotherapy. Another one may be very effective in working with the emotionally disturbed and have little to offer in working with the blind. In medicine we are accustomed to the various specialty panels: psychiatr orthopedics, internal medicine, and so on. In psychology, unfortunately, the fact that a person has a particular level such as Clinical Psychologist, for example, is not sufficient evidence of the types of services he is prepared to perform. We have proposed several panels, but we have elected to designate them in terms of specific services rather than specialty areas. We are not too concerned with the label of the psychologist as long as he can demonstrate that he is competent to perform a particular service.

Separate Panels on a Functional Base

I would like to describe the proposed panels for providing evaluation services to the Division in general. They consist of the Intellectual Evaluation and the Clinical Personality Evaluation.

The primary purpose of the Intellectual Evaluation is to provide a measure of a client's current intellectual functioning, to give a description of the pattern of specific strengths and weaknesses in intellectual ability, and to furnish an estimate of any intellectual deficit that may be present. This information will be used as an aid in reaching a determination as to a client's eligibility for services and/or in developing a vocational rehabilitation plan. The evaluation will be based on an interview and on an individually administered standardized intelligence scale. In most instances, the Wechsler Adult Intelligence Scale or the Wechsler Intelligence Scale for Children will probably be the most appropriate instruments.

The Clinical Personality Evaluation includes the Intellectual Evaluation and a personality evaluation based primarily on projective techniques. The purpose of the Clinical Personality Evaluation is to provide an assessment of intellectual and personality factors to be used as an aid in reaching a determination as to a client's eligibliity for services and/or in developing a vocational rehabilitation plan, with consideration of personality dynamics and concomitant strengths and weaknesses. Paper-and-pencil personality tests may be included in the battery, but they should not be utilized as a substitute for projective instruments. Unless there is some good reason to the contrary for which an explanation is given, it will be expected that the Rorschach will be included in the test battery. The Clinical Personality Evaluation is utilized when more information regarding personality factors is required than would be furnished by the Intellectual Evaluation.

Two additional panels have been proposed for providing evaluation services to the Disability Determination Unit. They have been labeled Intellectual Disability Determination and Personality Disability Determination.

The purpose of the Intellectual Disability Determination is to provide an assessment of intellectual functioning (similar to that of the Intellectual Evaluation previously described) in the context of the aims of the program of the Disability Determination Unit. This may be simply to determine a valid intelligence level for purposes of determining eligibility for Social Security benefits and/or to determine prognosis and possible feasibility of rehabilitation efforts. Considerable clinical experience and skill may be called for in obtaining valid estimates of present and previous levels of functioning, in rendering opinions as to the probable basis for limitation, and in differentiating retardation in functioning due to mental deficiency, brain damage or deterioration, or emotional disturbance, for example.

The purpose of the Personality Disability Determination panel is to provide an assessment of personality functioning of Social Security claimants to aid in determination of eligibility for benefits and/or for rehabilitation efforts. A considerable degree of clinical experience and skill is required in providing such assessments as the following: estimates of deterioration in borderline clients where the specific diagnosis is already clear, evaluation of residual ego resources in an acute disorder, re-examination of chronic cases to estimate progressive changes, or personality evaluation following a functional diagnosis by an internist.

In proposing these panels, we attempted first to describe the services to be performed and then to set standards for membership on the panels so that the rehabilitation counselors would be able to identify psychologists who were competent to perform specific services. For the Clinical Personality Evaluation, for example, it was specified that the panel member must have specialized training and experience in the dynamic assessment of personality with projective techniques (including the Rorschach and the Thematic Apperception Test). For Personality Disability Determination, it was required that the panel member must have three years of post-doctoral experience in personality evaluations with a clinical orientation and obtain familiarity with the aims and policies of the program of the Disability Determination Unit.

I would like to emphasize that we are not suggesting that the services that have been described are the only types of evaluation and assessment services to be provided. We have been trying to describe what we consider to be typical services. These are primarily oriented in the direction of clinically established instruments of demonstrated effectiveness. It is anticipated that counseling and/or educational type evaluations can be designated as services to be used for rehabilitation planning purposes with many agency clients. Another possibility is that questionnaire methods in various stages of research development at present can be adapted to service in the future.

You don't have to take a very close look to see the flaws in these proposals. It would be foolish to suggest at this stage that this particular approach could serve as a model. It may or may not have merit, but it does represent an attempt to deal with a problem which to my knowledge has been almost completely neglected.

SOME CONSIDERATIONS IN EVALUATING BEHAVIOR DISORDERS

David A. Schriemer

Mr. Schriemer's informal presentation described the problems faced by the rehabilitation counselor in dealing with diagnosis and rehabilitation of clients with behavior disorders. The material which follows outlines the dimensions of this aspect of counseling practice and highlights the need for psychological consultation.

THE EVALUATION OF BEHAVIOR DISORDER CASES

The Referral: Although the referral of a behavior disorder case may come from any source, there will be a high incidence of referral from O.E.O., Department of Public Welfare, Manpower and Development Training Programs, Model Cities, the Division of Youth Services, Division of Corrections, and other programs. In many instances referrals are made to the Division of Vocational Rehabilitation, not on a basis of behavior disorder, but rather as a referral for dental services, visual problems, psychiatric disorders, and possibly minor medical services. Very often, the typical referral of a behavior disorder case is not referred for that reason, but rather for some other more traditional reason. The referral source frequently does not understand the agency's concept of a behavior disorder as it applies under the new regulations. Therefore, the agency is being used in a more traditional role and often a client is referred with the comment, "You go to the Vocational Rehabilitation office and they will fix your teeth."

Because of the referral system and its inherent difficulties, the behavior disorder case is often over-looked or mishandled. This presents a unique counseling problem in that it raises the necessity for reinterpretation of the agency's role, and a restructuring of the agency's services, policies, and client expectations. The client who is referred for dental services can often be developed as a behavior disorder case with appropriate documentation enabling the counselor to effectively deal with the "real" problem. However, this maneuver requires counseling skill in identifying the primary issues as well as developing the necessary documentation and evaluation materials. For example, the counselor who receives the referral from the O.E.O. or Manpower and Development Training Program is often asked initially to provide glasses or basic dental services. The eye or dental condition may not be severe enough to be a primary disability, but upon further counseling and investigation into the client's circumstances, it develops that the individual has significant educational, economic, social, and cultural deficiencies, in that he has been an underachiever in school, has been indigenous to a deprived and disadvantaged community, has been the victim of a rather severe and disorganized family situation, and in fact, presents a rather hostile attitude toward the larger community. The dental needs then appear to be secondary to the primary problem evidenced by this behavior disorder situation. The counselor should then begin to develop and establish the necessary documentation for rendering this individual eligible for vocational rehabilitation services based on a behavior disorder.

The Client: It is necessary for the counselor to develop a new frame of reference when dealing with the term behavior disorder. Primarily, behavior disorders appear as problems or reactions to an unfavorable environment, problems of personality development, problems of persistent and undesirable traits or habits, problems of delinquency or conduct disorders, problems of general educational and vocational deficiencies, and evidence of an inability to carry on normal relationships with family and community. Within the framework of this concept, it is not very difficult to classify many individuals who have been traditionally seen as mentally ill, psychoneurotic or neurotic. Most of the typical psychiatric, mental health or mental disability cases could fall within a behavior disorder category with appropriate documentation. However, it must be emphasized that the behavior disorder category is not designed for this more traditional classification and frequently the vocational rehabilitation counselor may inadvertently document a case as "behavior disorder" but in reality the evidence and the evaluation material will indicate a more serious problem in the area of mental illness.

The behavior disordered client, after major mental illness has been ruled out by appropriate psychological and psychiatric information, is the client who has very little insight into his own social and cultural difficulties. His family, though destructive, and disorganized, has been taken for granted; his community, although deprived and depressed, has been taken for granted; and in fact, his very "lot" in life has been taken for granted. He is reacting normally to a problem situation. The pathology is in the inadequate environment and his behavior is the result of that inadequate environment. His impaired ability to carry out normal relationships with family and community are no less real just because he is reacting "normally". Having accepted these conditions of life, the behavior disordered client presents a unique challenge to the counseling skills of the professional rehabilitation counselor.

The Counselor: Frequently the vocational rehabilitation counselor has attempted to develop information on a behavior disordered client by using familiar and traditional techniques. The psychological information reflects an adequate intelligence appraisal, but is grossly deficient in any social and cultural description of the client's environment and its affects on his life adjustment. The psychological report is often deficient in describing patterns of behavior and developmental factors which have influenced the client's life. In like manner, the psychiatrist is often used as a method or mechanism to rule out major mental illness, but the psychiatric report does not reflect the environmental and socio-cultural problems encountered by the client.

Having acquired such evidence, the vocational rehabilitation counselor is often "hard pressed" to pursue the evaluation further. It is usually at this point that the counselor's own attitude, motivation and personal philosophy interfere with good casework. Therefore, it is quite evident that in dealing with this new category of disability each vocational rehabilitation counselor must come to some understanding as to his own influence and attitudes which might affect the processing of this type of case. The counselor emerges as a key factor in the effective implementation of a program to rehabilitate the behavior disorder client. This is probably more true with this particular category than any other classification of disability. More than ever, the counselor's role in the documentation and evaluation of this type of case is of major significance, and likewise, any rehabilitation effort encompassing good planning, good quality of counseling, and rendering of appropriate services largely depends on the special skills and motivation of the rehabilitation counselor. No other category of disability offers the counselor such a significant and primary role in effectuating the rehabilitation of an individual as does the behavior disorder classification. It is imperative that every vocational rehabilitation counselor have a positive, well-motivated attitude toward serving this type of disability.

BEHAVIOR DISORDERS

(characterized by impaired ability to carry out
normal relationships with family and community)

Under the current law, the behavior disorder is not only characterized by deviant social behavior and identified by competent psychiatric documentation, but also includes behavioral problems characterized by impaired ability to carry out normal relationships with family and community. The etiology of such conditions, unlike the psychiatric disorders, are found in vocational, educational, cultural, social environmental, and other factors. Therefore, in order to properly document the "pathology" of behavioral disorders which are manifest by inability to carry on normal relationships with family and community, it is necessary to explore in detail those deviations from the normal which characterize the inability to adjust normally to family and community. In this context, the factors of education, culture, environment, social, and vocation should come under close scrutiny and be carefully evaluated to determine their influence on behavior. Such investigation into these dynamics must be documented by qualified psychologist after being identified and reported by a rehabilitation counselor or other designated person. The psychological advisory committee has accepted the role of the psychologist in documenting the evidence needed for this type of case. In identifying the "pathology" which deviates from the normal and is characteristic of an inability to adjust to family and community it may be necessary to explore in further detail the significant elements which might produce maladaptive behavior.

For example

1. Significant vocational factors may be reflected in the individual's inability to identify with work as a principal adult activity because of an ineffective or absent ego ideal with whom to identify. Disorganized family situations can result in negative worker role concepts and be detrimental to vocational adjustment.

2. Educational factors may be identified by the "dropping out" of an individual from school. Academic underachieving may be a reflection of a negative identification with the academic environment. An unsuitable curriculum may have been a factor.

3. Significant cultural factors such as unfavorable stereotyping of an individual may be severe enough to inhibit achievement. Such culturally identifiable factors as language usage, grooming, and manners may play a significant role in the inability of an individual to accept the value system of the larger society.

4. Environmental factors are often reflected in a poor or inadequate diet and nutritional deficiency existing from early childhood through adult life. Such factors would be a major deterrent to full participation in family and community life.

5. Social factors such as strong group identification may result in frequent truancy from home and school and prejudicial factors may further entrench social identification with inappropriate group behavior.

These comments represent only a sample of the kind of elements which may be uncovered in documentation of the factors which may play a significant role in the total life adjustment of an individual. Where such factors are identified and documented by a psychologist, and where these influences result in the inability to carry on a normal relationship with family and community, a behavior disorder may be established.

MEANINGFUL PSYCHOLOGICAL SERVICES -- THE PSYCHOLOGISTS' POINT OF VIEW

John E. Muthard

Introduction

In addressing myself to the topic assigned to me by Dr. Thomason, I will try to contribute to two of the listed objectives of this conference. As listed in your preliminary materials these are:

1. To develop a closer working relationship between psychology and vocational rehabilitation agencies.
2. To stimulate rehabilitation personnel toward greater use of psychological services in the rehabilitation process.

Hopefully my comments and meanderings may serve to support or embellish some of the objectives.

As I read the topic title "Meaningful Psychological Services -- The Psychologists' Point of View" it invites the speaker to define issues and problems as well as possible solutions or alternatives as he sees them. Mindful of the self reflexive and biasing character of any exposition of this type, I will try to focus on our mutual concern for providing quality rehabilitation services for clients as I discuss what is meaningful. Thus I will not limit myself to saying polite things to you. Rather I will hope to be constructively critical of what I've seen and heard about the use of psychologists by state VR agencies.

To look at the elements of this topic I formulated several questions.

In what ways can agencies make effective use of the skills and knowledge of their consulting psychologists? OR from the agency's point of view, how can you get the most help from your psychologist consultant?

What kinds of services for clients and counselors should the psychologist provide?

What problems and issues arise from the expectations the agency has for the psychologist, psychologist for agency, counselor for psychologist and vice versa and client for psychologist and vice versa?

IN WHAT WAYS CAN AGENCIES MAKE EFFECTIVE USE OF THE KNOWLEDGE AND SKILLS OF THEIR CONSULTING PSYCHOLOGISTS?

I think it well from the start to note and accept the reality of individual differences among agencies as well as psychologists. As I see it, in the past the programs and orientations of many agencies have offered limited opportunity for the competent psychologists. The kinds of help counselors sought did not represent a challenge and the rewards they offered, whether psychic or in the coin of the realm, tended to be minimal. On the other hand, psychologists range in qualifications from the diplomate in clinical or counseling psychology to individuals who had some graduate training in school psychology work or school counseling. They include people who have a genuine interest in the rehabilitation program and serving clients and individuals who couldn't care less. I think that with such differences and the greatly expanded need and demand for psychological services in the past decade it is understandable that both misuse of psychologists and misunderstandings between counselors and psychologists might arise and that some agencies might not use psychological consultants extensively and that some psychologists would not seek a relationship with agencies. What I have just said may be of use to you as I discuss this topic. You may always turn to the comforting thought that I as a psychologist do not perform that way or we as an agency don't do these things.

To turn to the questions:

IN WHAT WAYS CAN AGENCIES MAKE EFFECTIVE USE OF THE KNOWLEDGES, COMPETENCIES, AND SKILLS OF THEIR CONSULTING PSYCHOLOGISTS? Perhaps first of all they need to decide for themselves what kinds of help they want from consulting psychologists. It seems to me that this decision needs to recognize that the agency or the counselor may see their problem in limited ways; e.g. see a need for vocational evaluation alone, when the client cannot consider or act upon any alternatives until he resolves the conflict within himself or between him and members of his family. Thus, I believe that as a first step toward developing meaningful psychological services, state agencies need to examine--in somewhat the same fashion as we are doing here--the ways in which client needs can be either directly or indirectly served by using psychologists. Such an examination needs to be done with psychologists who have demonstrated an understanding and interest in the problems of the agency and its clients and who have shown some talent for coping with these problems. I further believe that such thinking needs to be done at home and not just here in Gainesville; it needs to accept the realities of the state program for which the psychologist's services will be used. Although the advice of established consultants should be obtained, I would strongly recommend using the consultation of clinical and counseling psychologists in your state who have broad experience with the ways in which psychologists can be useful to your agency. Perhaps a good avenue for doing this would be your state psychological association. Such discussions would not develop prescriptions for the use of psychologists, but would instead serve to clarify the variety of ways in which psychologists can help. It would very likely underline the professional character of psychological consultation services and minimize misuse and misunderstandings about what psychologists can and should do.

Let's examine for a moment the major areas in which psychologists can be expected to contribute.

Five areas of psychological service which can contribute to the resolution of rehabilitation problems have been listed by Wright (APA), in her report of the Princeton Conference, Psychology and Rehabilitation.are:

1. Psychological assessment of the patient: involves the appraisal, evaluation, diagnosis, or some combination of these activities, of the client. Assessment includes the psychological study of the individual including background data, interview impressions, as well as appropriate psychological testing.

2. Counseling and psychotherapy: includes individual work with clients, group counseling or therapy with clients, and possibly work with persons significantly involved in the client's planning. It may well include consultation with counselors about their own counselor activity.

3. Consultation and integration of services: includes consultation with the counselor or other members of the rehabilitation team, perhaps even other agencies to assure coordinated and integrated services for clients.

4. Education and training:
a) contributing to the psychological sophistication of other professional personnel concerned with disability--e.g. counselors, vocational evaluators, etc.
b) participating in programs of intra-agency, inter-agency, or public education and;
c) supervising the training of psychological or counselor trainees.

5. Research: The psychologist, depending upon his own training and inclinations, can offer research consultation in various areas and at different levels with respect to such problems as understanding the impaired clients or the creation of better methods for delivering services to clients.

The foregoing list was paraphrased to suit our purposes from the discussions at the Princeton Conference which was held 10 years ago. In broad outline it is just as valid a description of what a psychologist might do in rehabilitation today as it was then. Although hard data are not available, it is my impression that no great advances have been made within state agencies in using psychologists in the last four roles. I do know that Georgia, South Carolina, Florida and Alabama have either staff psychologists or a close working relationship with a psychologist to undertake certain research problems. Other states have begun to work with university based psychologists to conduct research and a few have employed research psychologists, but this is far from a widespread development. For the most part psychological consultants are used in the evaluative function and to a lesser extent in the consultation role. Since by this time in the conference you will have heard a good deal about what is being done I'll not belabor the description of what can be done, but look more closely at isuues and problems associating with making optimal use of psychologists.

Agency - Psychologist Relationship

They need to define bounderies of psychological service.

1. Principle: An individual psychologist should be requested to undertake only those tasks for which he has established competence. On the other hand the psychologist has responsibility for not presuming to offer services of a type for which he has limited competence.

The competency of the psychologist who serves rehabilitation clients should be a concern of both agencies and psychologists. Responsible psychologists do not purport to offer services for which they lack competencies. This is the individual psychologist's problem, but its converse - the need for the agency to be assured that their clients are receiving competent service is an agency problem. To some extent, it is also a problem of the profession of psychology - as I see it this means the state psychological associations. Agencies and professional associations need to develop understandings which persuade more psychologists to provide consultation services to rehabilitation clients. This, from the viewpoint of the psychologist, means having a professionally challenging task, being informed of the impact of his help, and being compensated at a suitable level. When the fee schedule for evaluations or other services are significantly lower than what such services bring from other sources or clients we can anticipate that many competent psychologists will not undertake vocational rehabilitation consultation.

It seems to me that the agency, counselor, and client can expect to secure better assistance if an extended working relationship is established with a small group of interested and qualified psychologists in each district rather than working only occasionally with a large number. Although the competence of the psychologist should be of prime concern it is almost equally important that he have an interest in rehabilitation and develop an understanding of the goals of the agency and its counselors. This I think carries with it an expectation that he will want to learn about the agency and also be ready to provide informal as well as occasionally formal learning experiences to counselors. I should think that in the process of involving psychologists who they want to have as consultants, that it might be advantageous to provide an opportunity for the psychologist to learn more about the agency through meetings with agency staff. I think ways should be found so that he can be compensated for such sessions.

2. Agency and psychologist need to discuss forthrightly the implications of having the psychologist describe clients as disabled by behavior disorder when the individual's behavior patterns are not deviant within his cultural sub-strata.

Examples: The Indian who forsakes work to attend a family gathering. The young migrant worker who has average intelligence but can't read anything but simple signs. The Negro sharecropper who had employable capacities prior to the advent of the cotton picker, but has been essentially unemployed for several years. Are all these behavior disorders?

What does assigning this label do besides make them eligible for services?

Does it say that these individuals who are unable to compete without rehabilitation services are misfits? Does it imply that what is wrong is wrong with the individual and absolve the community for its neglect whether it be in providing education or re-employment assistance.

And yet this semantic juggling may open opportunities otherwise inaccessible to those who are misfits in a modern economy, but who are not deviant among their lower socio-economic class friends.

DIAGNOSING BEHAVIOR DISORDERS

I agree with those of you who yesterday expressed some concern about the possible misuse and abuse of the certification of disability, namely behavior disorders. It seems to me that in adhering to the well established pattern for determining eligibility --- the requirement for physician or psychologist determined disability --- vocational rehabilitation agencies will in many instances be wasting their resources and misusing psychologists by asking them to certify that individuals who are socially and culturally deprived do indeed have behavior disorders. I say this because it seems to me that any conscientious counselor can determine, after a thorough interview, that such a condition does exist. I believe that any difficulties he might have in making such a determination would be the same as those which would face the psychologist. Both need to know what criteria are to be applied in making such classifications. If they are primarily the presence or absence of basic skills and knowledge, do we need a psychologist to tell us so? If it is a matter of lacking attitudes and approaches to work which are inappropriate to the client's present circumstances do we need to be told so by a psychologist. If it is knowing that the client can't secure work .... I don't think so.

Perhaps much of my difficulty with the behavior disorder issue arises from a certain amount of semantic rigidity on my part. I've always understood the behavior disorders to include the full range of neuroses and psychoses. So far as I know our handbooks of abnormal psychology or behavior disorders don't have rubrics for the socially and culturally deprived. The somewhat heretic thought occurs to me; maybe vocational rehabilitation agencies should ask social workers to make the determination regarding social and cultural deprivation.

However, if the psychologist's role is not primarily to provide a disability label to the client and if instead he is asked to use his skills to determine what kind of person the client is and wants to become I can certainly see a legitimate role for the psychologist. If he can help the client and counselor develop approaches which will enable the client to move toward self sufficiency and the assumption of his responsibilities to himself and others, then the psychologist has a legitimate role.

COMMUNICATION BETWEEN PSYCHOLOGY AND REHABILITATION

After the issues of boundaries, competencies, and the basic relationship of the psychologist are considered and worked through, a large share of the responsibility for the effective use of psychologists rests with counselors and indirectly their supervisors. In keeping with what I've said before, they need to encourage interest and involvement in the rehabilitation process by psychologists in their area. They also need to know, just as they know for other resources, the kinds of assistance they can expect from each psychologist.

Certainly one of the key contributions which the counselor can make to effective use of the psychologist is through his discussions with the client about the nature of this special assistance. The client needs to know in simple language how the client and counselor may better be able to make plans or in what specific ways the session with the psychologist will be helpful. The counselor has the responsibility for allaying anxiety or apprehension about going to a "head shrinker." Quite obviously he should provide the client with definite instructions about where and when he will see the psychologist and how and when the client will find out about the psychologist's report, if there is to be one.

In those instances where the psychologist is asked to make an assessment of the client's resources and potentials, I think it desirable for the counselor to submit the following types of information to the psychologist:

1) A summary of the client's experience with the agency. What has been done thus far?
2) A summary of basic medical, psychiatric, psychological, or other evaluative information.
3) A brief statement of current or recent situational difficulties which might be expected to affect the client's current behavior.

Finally, I think it imperative that the counselor tells the psychologist what questions he and the client are seeking assistance with by psychological consultation.

Thus far the focus of my remarks have been on the agency and counselor responsibilities. Let's turn to what I think the psychologist needs to do. As in the rest of his psychological practice, he needs to respond to the state vocational rehabilitation agency client in ways which show acceptance and a respect for the client as a person. He needs to be sure that the client understands the purposes of his work with the psychologist. Such mundane matters as why the client is there, what he will do, how it will help him, and how much time it will take are matters which often need to be clarified. While we are talking about structuring, I might also reiterate the concern for having the client know how the information or recommendations gleaned from his association with the psychologist will be given to him.

Just what should be the outcome of meaningful psychological services provided by a psychologist? Quite simply, such services result in understandings and information for the client and counselor which help meet the rehabilitation needs of the client. In keeping with the positive orientation of rehabilitation, there needs to be a focus in evaluative consultations upon the resources and unique qualities of the client which help define what he can do. Although pathology and deficiencies need to be recognized and the limits they impose upon the plans and actions of the client and counselor recognized and reported, they should not be the focus of the client evaluation. The counselor is interested in knowing about the potentials of the individual --- what he might be able to master or learn, what interpersonal skills he might enhance --- and the resources or skills the client now has.

When we ask just what should be in a desirable psychological report to the rehabilitation counselor, my first reaction is to recomment strongly that you turn to DiMichael's 1948 paper in the Journal of Consulting Psychology. I'm sure that permission to reprint this could be obtained and would strongly recommend it to psychologists consulting with rehabilitation counselors. Among his suggestions were: the report should be written in language appropriate to the reader and the psychologist should recognize his role as a specialist who is asked to provide otherwise unavailable observations and evaluations and should not attempt to develop vocational plans for and with the client.

THE PSYCHOLOGIST'S REPORT

DiMichael suggested five general sections for the desirable psychological report. As I list them I will paraphrase some of his suggestions regarding each section.

1. Observations on the client's behavior

   Those aspects of the client's behavior which appear to have significance for readiness for rehabilitation and his vocational adjustment should be noted. The psychologist has the responsibility for interpreting his observations in the context of other information about the client.

2. Technical Results

   These should be presented in a brief, technical manner. Graphic means should be used when feasible.

3. Interpretation of test results

   A narrative report of the present functioning of the individual as determined through tests and interviews should be submitted. Interpretations should not be linked to specific occupations, but rather should be related to broad areas of work at levels appropriate to the client's intellectual, educational, and other background. Example: Above average aptitude in visualizing spatial relationships --- different levels: engineer, technician, draftsman, inspector---task oriented rather than job oriented.

4. Recommendations

Here the psychologist synthesizes his impressions of the client as gained from interviews, observations, and tests. Recommendations should give some impression of the personality dynamics of the client as well as suggest work situations which are potentially suitable to the client as seen by the psychologist. It is usually best for the consultant to avoid specificity with respect to occupations both in his report to the counselor and his comments to the client.

5. Summary

It should answer concisely the questions raised by the counselor in his referral.

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PSYCHOLOGICAL SERVICES TO AGENCIES FOR THE BLIND

Mary K. Bauman

Why should we talk particularly about psychological services for agencies for the blind? From the psychologist's point of view, how can it be different to work with blind people - different from working with "normal" people, different from working with other handicapped persons?

Are blind clients different? Certainly they are not different in any single way or even any readily identifiable combination of ways. Although one often hears the term, there is no "the blind" in the sense that all or most blind people are alike.

Indeed, blind people differ in all of the ways in which seeing people differ and in addition they differ on a number of qualities related to their blindness. Therefore, blind people have more ways of being different than sighted people do.

For example, within the group classified legally as blind, individuals differ greatly in amount and kind of vision, ranging from those who are totally blind to those having 20/200, which means that they see, at twenty feet what normal people see at 200 feet. Thus, there are tremendous and vocationally very significant differences among people called "blind" on just this one factor of visual acuity.

Yet this matter of what people can see is far more complex than mere differences on ophthalmological reports might imply. Indeed, as we work with blind people, we often find little relationship between the ophthalmological report and what individuals can do with their remaining vision. In some types of eye problems the individual has "good" days and "bad" days depending upon his physical condition. If the opthalmologist saw him on a "bad" day and we test him on a "good" day, we will find him able to use far more vision than we would have expected from the acuity report - but the reverse is just as possible. Again, some eye conditions make it quite difficult for the individual to see in certain kinds of light - for some a bright light, for others a dull light. Another factor in how much a person of a certain acuity rating can do with his vision is his own motivation. Some people are very anxious to use their vision and have learned to respond to very slight cues; others readily assume they cannot see what is before them and seem to make little effort to do so.

In addition to variations in acuity, clients differ in the nature of their field of vision, for some very constricted, for others damaged in the center but usable at the periphery, etc. Other types of retinal damage may result in vision only in certain areas and/or distortion of the image. It might be fair to say that all people with a certain acuity do not see the same thing nor see it with the same ease, or under the same conditions of light, etc.

From the psychologist's point of view, another very significant way in which blind people differ is in the age of their loss of vision. Those who retained good vision into their youth or beyond have developed concepts of the world around them like those of persons with normal sight and, depending upon the age of loss, they may have had all their education as seeing persons, or even entered upon a career as a seeing person. How different they are psychologically from those who are blind from birth or from a very early age! For these latter, many concepts, if present at all, are based upon verbal report from those around them; examples would be clouds, or color. Other concepts may be built up from partial experiences, as the concept of fire which could involve the sensation of heat (perhaps even of pain if the individual was ever burned) but otherwise consists only of what he has been told. Yet blind people use the words of the seeing world and usually use them correctly. As we work psychologically with them, where we cannot take the meanings of words casually or at face value, it may be necessary to take time to determine whether the blind person really has the typical concept of seeing persons in relation to the words he uses. In testing for dexterity, for example, we often find that the blind person does not respond correctly to such directions as "up," "down," and "across." He simply does not know what action he should take in response to these words.

Another major way in which blind people differ, a way having great psychological significance, is in how they feel about blindness and about themselves as blind people. This depends upon many things, of which I shall list only a few. Some of these factors are within them --- their age, their health, their mental ability and problem solving ability, their capacity for finding some compensations. Other factors are outside the individual, such as how his family treated him, whether they were too protective, whether they felt guilt for his blindness and over-compensated, or whether they chose to abandon him, either in fact or psychologically. In some cases the blind person is kept dependent and immature because one or more people in his family need someone to depend upon them --- they encourage dependence in the blind person and may even fight rehabilitation efforts to make him independent. In some cases, the individual's attitude toward his blindness is affected by the way he lost his vision. It is far different to be blind because of attempted suicide or because the diabetic has failed to follow his doctor's orders or to be blind as a result of defending one's country in a war. Attitudes toward blindness are also much affected by whether the individual has lost his vision suddenly and permanently in a way which leaves no hope of recovery, such as an accident in which the eye is damaged and must be removed; or whether his visual loss came gradually due to some condition which he always hopes will be reversable. How many people spend months, even years, going from one physician to another in the hope of finding a "cure." Doing this often keeps them from considering rehabilitation.

Blind clients differ in the effects which blindness has had upon them. One of the obvious ways in which it can affect a young blind person is in his education. If he was taken from his home and placed, at an early age, in a residential school he may feel far from close, emotionally, to his family and he may have no friends in his home town where he was essentially a summer visitor. If he remained in his home and attended a local school, it is psychologically important to know how much help he had, whether it was adequate to enable him really to learn or whether he could merely sit in class and pick up what he could without special attention. On the other hand, some blind children have "readers" who are really tutors so they have far better school records than they could have achieved, on their own as seeing students. Unfortunately, it is still true that some teachers feel they cannot give a poor grade to a blind student, so we often find good academic records at the high school or even the college level but these have not been earned; when the individual tries to go on to a more realistically competitive situation, such as a job or graduate school, it may turn out that he was ill prepared.

Obviously blindness affects employment opportunities. Many jobs require vision and cannot be done at all - such as accounting - while others can be managed only with special aids. However, much the most serious difficulty lies not in what job can or cannot be done but in acceptance by employers. Or, if employed, the blind person too often finds he has no opportunity for promotion since the employer thinks he can do just that one job. Because of the difficulty in obtaining employment, the blind person has far less job mobility than the seeing, he often feels he dare not quit and take the chance that he can find another job. The psychological frustrations in such a situation are painful and may well result in deeper emotional problems which, in turn, come to the psychologist for solution.

Less often listed are the problems of the blind person in obtaining normal opportunities to learn and to adjust socially. It is difficult for blind youth to master social graces when they cannot see what others do and how they do it. Some try to make one or two early friendships and cling to them, fearful of having to meet new people. Some are anxious about their acceptance by seeing people and cling to blind friends, not out of affection or enjoyment of their company, but for support. The limitation in opportunities for finding a seeing mate and the psychological blocks to marriage with a sighted person often drive two blind individuals together.

Some blind people also list as a source of frustration their limitation in opportunities for enjoyment, enrichment, and competition with sighted people in the world around them. Problems in getting the reading material of their choice and getting it when they want it may be considerable, although library service is constantly improving. Hobbies are relatively limited and enjoyment of many athletic games held to listening to them on the radio. In some of our research it was interesting to note that one of the very frequent answers to our question about how blindness most limited the person was that he could not drive; both the sheer pleasure of controlling and driving the car, and the freedom to go where one wishes when one wishes may be lost.

From the point of view of the psychologist, especially the psychologist who would like to do research related to blindness, it is important to note that blind people are not normally distributed in the population. Blindness is especially characteristic of old age and more than half of the blind people are elderly. In recent years, we also have a very high percentage among the young blind who are multiply handicapped.

By comparison with persons of normal vision, blind people differ greatly in the tensions under which they must live. Again I can list only a few examples: It often takes much longer for the blind person to complete a task because he must often do it by touch which is frequently a very time-consuming way to get information. Even if he can use hearing to get his information, it usually takes much longer to have material read to one than to skim it oneself visually. So the blind person must always allow more time to accomplish almost any task.

For many of us there is tension in having to share private information with others - yet the blind person must do this constantly. Most of his letters must be read to him, his bank records, his taxes - none of these are his alone. This in turn highlights the many situations in which dependence is forced upon the blind person, no matter how anxious he is to be independent. He must face the fact that some things cannot be done at all without the aid of a seeing person, other things can be done much more quickly or effectively with the aid of a seeing person - and when he fights this (as some do) he only makes more trouble for himself and others.

Nor can we overlook the fact that the blind person is in greater physical danger than the seeing. The totally blind person may be an excellent traveler but he must constantly attend to a number of cues in order not to be injured, especially in travel and especially in an unfamiliar place. I do not refer merely to the dangers of crossing a busy street (for which he can often receive assistance) but the open manhole, the unexpected pole, the obstacle on the walk, all of which can have painful results.

In addition, the blind person often finds that he is regarded as public property, his privacy constantly invaded. Strangers address him, not merely to offer aid (which may be gratefully accepted), but to ask personal questions and to give unwanted advice. Moreover, to be totally blind is to stand out; one cannot be unobtrusive about traveling down a street without vision, whether one uses the cane or the dog as an aid.

What, then, are the services which psychologists may offer to blind people and to the organization which serve them?

One of the most frequent services is psychological evaluation, especially for educational and vocational planning. Since this service is so well known I will merely point out that such evaluation may be far more important for the blind person than for the seeing precisely because of the educational problems already listed and because it is often difficult for the blind young person to obtain real knowledge of the world of work and he may, therefore, have fastened upon a pretty unrealistic choice of goal.

A second obvious service area is that of therapy, all the more frequently necessary because of the numerous tensions under which the blind person lives, as noted above. He very often has real reason to feel insecurity, to be troubled by dependency, to feel rejected, and he may at times almost cling to his blindness as an excuse not to face the competitive world. A step toward rehabilitation may then be therapy. In rehabilitation centers and schools, places where a number of blind persons are together, the psychologist may find group therapy very effective. A special area of counseling may be that with parents of blind children and perhaps with blind parents of seeing children (since when two blind people marry, their offspring may be normally sighted). Marital counseling may be more than usually necessary when a person loses his vision after marriage; too often this ends in a broken marriage.

We have alraady noted that many blind people are elderly. Although this is an area in which little seems to have been done to date, the psychologist may well have a special function here to keep the older blind person from simply giving up, becoming far more dependent than he needs to be. A very complex psychological area is that of work with the multiply handicapped blind, especially the deaf-blind and the mentally retarded. Unfortunately we have good reason to suppose that the numbers of these people is greatly increasing and their need for highly specialized services is great.

A growing field for the psychologist is that of in-service training for staff of agencies for the blind. In part because the need for staff has grown far faster than has the supply, many agencies are trying to develop staff from within and the psychologist can make a major contribution here. Another service, too little used to date, is that of counseling counselors. The fact that an individual is a counselor does not keep him from having psychological problems which may be intensified by his work with blindness in other people - and this is especially true when he is blind himself. The dangers of taking on your clients' problem are considerable for some workers.

A tremendous area, in which very little has yet been done related to blindness, is educational psychology. We know very little about the processes of learning without vision. Some work has been done in relation to reading but it is only scratching the surface. I have already noted that there is an increasing number of multiply handicapped blind and their educational problems need immediate study in the hope that better teaching methods can be devised both from the point of view of helping each individual more and from the point of view of coping, with limited staff, with a wave of severely disabled young people. Even the relatively defined area of developing more appropriate tests for the blind people could keep many psychologists busy for a long while!

To date, psychologists have been very little used by agencies for the blind in areas which, in the business world, are quite familiar to psychology. For example, the matter of public relations is of great concern to many agencies, yet they are only beginning to use professional help to attack this problem. Developing good relationships with employers so that more blind workers can be placed is a constant source of concern yet I know of no real application of psychological study to this. In development of adult training programs, such as "adjustment" and pre-vocatoonal training, psychologists are used only rarely and usually only to evaluate the clients, not to advise on the procedures used in training.

Finally, there are many areas of research related to blindness where the psychologist is needed. Problems of motivation, key to all rehabilitation, are perhaps most in need of this kind of study. Problems of personality, especially as blindness and its frustrations play a part, could, if solved, greatly increase rehabilitation closures. On the other hand, perhaps the blind person need not always be the recipient of help; perhaps he could be used very effectively as a counselor to other underprivileged groups. There is some evidence that this can be done wiht great success and this needs much further and immediate study.

As I consider the role of the psychologist in relation to blind people, listing all the ways in which blind people are "different," I cannot fail also to ask, are we, the psychologists, different when we work with blind people? What about our own feelings about blindness, our own emotions, fears and prejudices? We are not without them and we must first deal with them if we are to help our client. Most of our fears relate to what to do for a blind person and how to relate to him. These are special skills which we must make the effort to acquire. We must learn what to say to the blind person coming to our office or school, learn to tell him gracefully the things which sight would tell any other client, learn to guide him well, learn to ask him what help he needs and wants. And we must learn to say the word, "blind," without showing special emotion about it. And we must learn to laugh with our blind client, to enjoy being with him and let him enjoy being with us.

Some of our fears are genuine professional fears, concerned with the inadequacy of our special materials, special tests, etc., and concerned with our humble (and often correct!) feeling that we do not handle special tests for the blind very gracefully because we have so little practice with them. For the psychologist who will see only one or two blind clients a year this is truly a problem. Contrary to the situation twenty-five years ago, there is now a literature to which we can turn for help, there are manuals, there are special tests with suitable norms. We have merely to learn to use these things well. And we cannot learn by doing nothing.

RECOMMENDATIONS RE: USE OF PSYCHOLOGISTS IN VOCATIONAL REHABILITATION

ALABAMA

1. Social and cultural deprivation is a situation which should be defined by others, not by psychologists. Eligibility is an administrative decision and is not a problem of the psychologists.

2. The confusion in the minds of the general public that anyone who is socially and culturally deprived is eligible for rehabilitation services should be dispelled.

3. It pays for the psychologist to know the counselor to be appraised of what he knows about the client and what he expects from the psychologist.

4. The cycle of communication is the psychologist must know what the counselor's need is, the counselors must know what the state needs, the state must know what the federal government wants. The vague statements in some of the federal agency documents need to be clarified.

5. It is proposed that the advisory committee be organized into a statewide committee composed of the chairman and one psychologist from each of the five geographical areas in the state.

6. Members of the committee would not be representatives of the Alabama Association as such, but might act as officers to keep the association informed of activities and needs of the rehabilitation services. They would also work with the association on common problems.

7. The committee would meet as it's advisory services were needed by the state office.

8. The members of the committee might serve as consultants to individual clients and to propose needed research.

9. One day of service per week was suggested. To adequately serve the state, there should possibly be a full-time chairman. These were just suggestions for further development. Provisions would be made for committee members to be paid for their services.

10. A list of problems proposed for study by the committee.

    a. Fee schedules for psychological services. A uniform fee for equivalent services much better than negotiated contract and a study of this fee schedule will be made.

    b. Greater efficiency in rendering services. The use of sub-doctoral or unlicensed psychologists under the supervision of a licensed psychologist in the provision of psychological services.

    c. Psychological diagnosis' are not necessary for all clients. They are required when there is a change in jobs or further training or entering college or in determining eligibility.

d. To get rapport of the psychologists we need to involve more of them. How should we go about it?

e. Another problem is the statewide educational program regarding psychological services. An educational program will be planned first to develop a closer relationship between psychologists and vocational rehabilitation agencies and second to stimulate rehabilitation personnel for greater and more effective use of psychological services in the rehabilitation process.

f. Lastly, in Alabama a psychologist is legally approved to diagnose and do psychological evaluation and therapy without supervision of a psychiatrist.

GEORGIA

1. The major problem we sense is communication. To be more specific, it's communication between psychologists and rehabilitation people. Communication among psychologists themselves and communication in the agency.

2. Specific administrative decision in the agency does not always match counselor behavior.

3. The state psychological consultant encounters obvious abuses in a permissive system. So the obvious solution to this is a restrictive structure and the obvious response of psychologists to this is to say that you're not going to tell me how to run my office. So the psychologist sets out to break the structure and if he does, we're back to the beginning again with a permissive system which gets abused. This gets to be a vicious circle.

4. Some benefit may accrue to us if we distinguish between the issues of validity, relevance and communication. Now we can argue for a long time about the validity of the W.A.I.S. test to the M.M.P.I. but we really ought not to expect rehabilitation to solve that problem when we as psychologists can't solve it.

5. The agency has to face normal government standards and that means specifically that when an abuse occurs the state administrator is going to be sitting on Capitol Hill with a legislative committee. Some legislature is going to say, "How do you explain this?" Course the way he explains it is he's going to come and ask Bob, "How do you explain this?" He's going to get the consultant and so on down the line. There is a need for the agency to be able to show that it gets its money's worth and in fact, there is a need for them to get their money's worth.

6. The agency wants protection against the unscrupulous practioner. None of us of course -- those other people out there. So the alternatives seem to be complete freedom for the psychologists so he can use what methods he wants which is quite likely to be abused as it historically has been abused.

7. Specifying what we want from the psychologists in the way of answers. Let the counselor specify the issues. Let the psychologist look among his techniques for those things he believes will help him in resolving the issues. Let him submit his billing on the basis of those techniques that he used perhaps in terms of some fee schedule that says such and such a technique is compensated with such and such a fee so long as the total of the techniques does not exceed a particular amount.

8. The problem of consultation -- it is not altogether the problem of the psychologist. Psychologists who are willing and anxious to give consultation to counselors sometimes found that the counselor resents his coming in and wasting their time; on the other hand counselors who want consultation can't seem to find the psychologist to give it to him.

9. Since counselors are imperfect, even when properly administered the psychologists who work with that office will be instructed to accept the referral without the issues being specified. To pick up the telephone and to call the counselor and say "Why?" "What are the issues, what do you want to know?" The psychologist will attempt as much as he can to answer the questions of the counselor and supervisor. Then, he would review not the report but the documents showing the action the counselor took on the basis of the report and finally then when the

psychological consultant comes in and he will be asked to give some time to consultation as an expression of interest in doing this and I don't think that is an unreasonable request. When the psychologist comes in hopefully his time will not be wasted. Both counselor and supervisor should be rather anxious at this time to talk to him and have his view of what action they would take and so on. Hopefully this might also make the psychologist a little more sophisticated about what are the action forces available to the counselor so that his references in the future might have more validity. Whether that will work or not we don't know, we'll try. I've got a couple of small other points that are peripherral to these issues.

10. Behavioral disorders do not occur only in culturally deprived areas. That's going to complicate life a little bit for the agency.

11. To abandon the concept of individual diagnostic evaluation of a client on which everything in rehabilitation has been based. It is conceivable that isn't how the problem is resolved.

12. We've always based rehabilitation thinking on the motivated client. In a very real sense what we'be been doing is skimming the cream off the top. Build the fence around the counselor's office and wait for the client to come in. Those who get there are likely to do pretty well. We have failed to reach thirty million people. If we're going to reach these people somebody has got to talk about creating motivation if that's what is required.

FLORIDA

1. Encourage an immediate stepping up of communication (at all levels) between rehabilitation counselors and psychologists in order to become better acquainted with services offered by each.

2. Top priority will be given to appointing a Psychological Advisory Committee of 8-10 members. Both Vocational Rehabilitation District Staffs and Florida Psychologists Association will be called upon to make nominations from which selections will be made by the Administration of the Division of Vocational Rehabilitation. The primary functions of the Psychological Advisory Committee will be to develop policies on use of psychologists in the operation of the Vocational Rehabilitation program and establish fair and reasonable fees for the provision of the various units of psychological services.

3. Employ a full-time or part-time State Psychological Consultant for the Division of Vocational Rehabilitation program. The recruitment of this individual will be done with the assistance of the Psychological Advisory Committee and the Florida Psychological Association.

4. It is recommended that district directors attend meetings of the Advisory Committee.

5. It is recommended that an Advisory Sub-Committee of professionals be established for the development of policies with respect to working with individuals with maladjusted problems caused by educational, social, vocational, and cultural factors. Members should be selected from psychologists, social workers, rehabilitation counselors and appropriate educational personnel.

6. All major universities in Florida will each have a psychologist representative on The Psychological Advisory Committee. The selection of psychologists will be from all geographical areas where psychologists are occupied.

7. Part-time district psychological consultants should be employed to provide case consultation for counselors and provide staff development instruction for rehabilitation staff members relative to counseling techniques, psychological service needs, group counseling, etc.

8. Communicate immediate with district V.R. staff regarding plans for a much closer working relationship with psychologists and advise them of the methods by which this close working relationship will be developed.

9. In order to accomplish the close working relationship desired, it is recommended that the Vocational Rehabilitation district officers work with a few rather than large numbers of psychologists. This will allow the development of interest and thorough understanding the Vocational Rehabilitation program and its psychological needs by the few psychologists. Vocational Rehabilitation should consider paying for the time of psychologist in developing this understanding of mutual roles. This may be accomplished at district staff meetings.

10. The Division of Vocational Rehabilitation should consider the possibility of using social investigators or other staff members in developing information regarding school, home, and community, factors contributing to maladjusted behavior of client. The determination of social and cultural deprivation may be more appropriately determined by social worker rather than psychologist.

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11. At time of referral, the following type of information should be provided by the Vocational Rehabilitation counselor to the psychologist:

a. Brief summary of client's experiences with the agency.
b. Other prior evaluative information which may have been developed.
c. Brief statement regarding client's current behavior difficulty.
d. Indication as to the specific type of information needed by counselor from the psychologist.

12. Psychological consultants on the staff of vocational rehabilitation will be used to assist in developing improved methods of pursuing vocational rehabilitation services which are psychologically related.

13. Written information relative to both typical and variety of services offered by vocational rehabilitation should be provided all psychologist working in relationship to rehabilitation counselors and rehabilitation programs. This written orientation information for referral will be carried on continually. The recommendations of this conference should be made available to other agencies dealing with handicapped clients, i.e., Florida Council for the Blind, Crippled Childrens Commission etc.

MISSISSIPPI

1. A brief explanation of the amendments and how the psychologists could help in serving Rehabilitation clients might be carried in the state psychological news letter which goes out twice a year. Now this was one effort that might be very good.

2. At the next state psychological meeting a spot on the floor be held for someone from Vocational Rehabilitation to really go into detail about our need for help.

3. We might work closely with the president of the state association who is in Jackson.

4.. An advisory committee and this committee could help in many ways. This committee would certainly be aware of the competence of the psychologists and we are not as well blessed as some states with psychologists. We have a few. We would like to know the areas of competence of these people and maybe the committee could help us in this sense.

5. Recently in our state, a certification law has been passed. With board certification this in itself will show the areas of competence of the psychologists. The committee might also help us with setting up standards of service which some states have said this is good and some say it's bad.

6. The committee could help with fee schedules.

7. In working out some details where we might have some face to face consultation with our psychologists throughout the state. We felt that from a state agency point of view, we might put forth some efforts to serve our behavioral disorders and others.

8. Special inservice training for our counselors because this is rather new to them and they're needing help. We might have a course of psychological services in our inservice program.

9. We might help our counselors in area meetings and other ways of developing a better communication between the counselor and the psychologist.

10. We as a state and perhaps this conference go on record as recommending that next year IPS adopt as one of its studies the topic of the use of psychological services in Vocational Rehabilitation.

11. We as a state group would recommend to our director that a committee of psychologists from over our state and the president of the association meet with us in order to chart our course in the responsibility of carrying out our responsibility to handicapped persons that need psychological services.

SOUTH CAROLINA

1. Possibility of a two-week workshop; Mary Bauman, leader for certain counselors and psychologists.

2. Application for a training grant to train psychologists to work in Vocational Rehabilitation.

3. More involvement of social workers working more closely with counselors.

4. Need for additional activities (staffing).

5. More emphasis possibly should be placed on group psychological procedures in the future.

6. A feeling of a tremendous need for follow-up information on the part of psychologists in relation to their clients.

7. Recommend that another meeting involving psychologists be held in the near future.

TENNESSEE

1. Establishment of a Professional Advisory Committee composed of psychologists and that the state agency (DVR) consider the desirability of establishing such a committee and, if approved, handle the mechanics of setting up such a committee.

2. Recommend that steps be taken to improve communication, or increase both communication and consultation between agency personnel and psychologists.

3. Establishment of, or making provision for, psychological consultation, in such areas as;
   a. Case consultation with rehabilitation counselors, if desired.
   b. In-service training with rehabilitation counselors.
   c. Guidance of individual counselors in their efforts, when time permits, for the busy counselor, of supportive counseling with their respective clients.
   d. Consultation regarding the desirability of requesting psychological evaluations in individual cases, or as to what questions are appropriate to ask of the psychologist when a client is referred for an evalu tion.
   e. Increased feedback regarding cases evaluated.

4. Recommend that the state agency give high priority to considering the topic, "Psychological Services in Rehabilitation" as an appropriate and timely topic for the consideration of the Institute on Rehabilitation Services (national meeting.)

5. Recommend that the state agency consider the possibility of having others in the state of Tennessee attend similar conferences (both personnel of agency and psychologists).

EDITORIAL COMMENT

The papers contained in this conference report represent significant additions to the literature of psychology's role in the rapidly developing field of vocational rehabilitation. Perhaps for the first time significant administrators, counselor educators and consulting psychologist focused on the practical problems which have tended to keep psychologists apart from rehabilitation counseling. While the interest of the meeting was essentially exploratory, the rapidity with which various state groups in discussion moved toward concrete recommendations for developing adequate psychological services in rehabilitation indicated their satisfaction with the scope and intensity of concepts discussed.

In general, the model of interaction selected by each state group (Region IV) was one of using a panel of consulting psychologists under the aegis of the respective state psychological associations, where these exist. While this suggests problems with respect to restrictive, state certification requirements, in some areas, the hope was that such a procedure would insure maintenance of a high quality of consultative service. For those states who chose not to adopt this model, their conclusions signify an intent to broaden and intensify the use of psychologists in new roles and with a variety of problems.

Word has arrived, since the conference, that there has been definite action taken by the various state agencies to further involve psychologists in their operations. The results of this meeting suggest that further meetings between psychologists and rehabilitation workers ought to be conducted.

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